UnitedHealthcare Insurance Company

Certificate of Coverage, including

- Medical Schedule of Benefits
- Outpatient Prescription Drugs Schedule of Benefits

Surest Plan B $4,000

For

Washoe County

Group Number: 78700349

Effective Date: January 1, 2024

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

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

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our

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

Offer Health Education Services to You

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

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

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

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

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

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

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

How Does Your Policy Work?

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

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

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

1. Acupuncture Services

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

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

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

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

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

2. Ambulance Services

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

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

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

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

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

We will reimburse the ambulance service directly if the Covered Health Care Service is not reimbursed by any other source.

3. Cellular and Gene Therapy

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

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

4. Clinical Trials

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

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

condition is interrupted. Benefits for clinical trials for cancer apply to any medical treatment provided in a Phase I, Phase II, Phase III or Phase IV for the treatment of cancer.

- Chronic fatigue syndrome. Benefits for clinical trials for chronic fatigue syndrome apply to any medical treatment provided in a Phase II, Phase III or Phase IV for the treatment of chronic fatigue syndrome.

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

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial. Benefits for clinical trials for cancer and for chronic fatigue syndrome are available only if the Covered Person has signed (before participation in the clinical trial or study) a statement of consent indicating that he or she has been informed of all of the following:

- The procedure to be undertaken.
- Alternative methods and treatments.
- The risks associated with participating in the clinical trial or study, including the general nature and extent of such risks.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)

- *Centers for Disease Control and Prevention (CDC)*.
- *Agency for Healthcare Research and Quality (AHRQ)*.
- *Centers for Medicare and Medicaid Services (CMS)*.
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- For clinical trials for cancer and chronic fatigue syndrome, be either:
  - Provided by a facility that is authorized to conduct Phase I clinical trials or studies for the treatment of cancer.
  - Provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner for a Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome.
- 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.

5. Dental Services - Accident and Medical

Accident Only

Dental services when all of the following are true:

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

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

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

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

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

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

Medical Only

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

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

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

Oral Surgery

Removal of erupted or impacted teeth.

6. Diabetes Services

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

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

- Training of a Covered Person after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies.
- Additional training as authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the Covered Person's symptoms or conditions that requires changes in the Covered Person's self-management regime.
- Periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

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

Diabetic Self-Management Items

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

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

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

DME and Supplies

Examples of DME and supplies include:

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

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

  Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

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

  - A medical exam.
  - A fitting by an audiologist.
  - A written prescription.

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

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

Prosthetic Devices

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

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

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

Orthotics

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

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

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

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

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

8. Emergency Health Care Services - Outpatient

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

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

9. Enteral Nutrition

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

10. Fertility Preservation for Iatrogenic Infertility

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

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

- Embryo cryo-preservation.

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

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

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

11. Gender Dysphoria

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

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

12. Habilitative Services

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

Habilitative services are limited to:

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

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

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

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.

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

We may require the following be provided:

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

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

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

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

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

13. Home Health Care

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

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

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

14. Hospice Care

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

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

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

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

15. Hospital - Inpatient Stay

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

Benefits are available for:

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

16. 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 for a mammogram every two years, or annually if ordered by a health care provider, for women 40 years of age or older.

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

- Genetic Testing ordered by a Physician which results in available medical treatment options. Limited to Genetic Testing for the following:
  - Cancer susceptibility.
  - Hereditary diseases.
  - Unspecified molecular pathology.
  - Fetal aneuploidy.
- Presumptive Drug Tests and Definitive Drug Tests.

Benefits also include:

- Cytologic screening test for women 18 years of age or older.
- Prostate cancer screening in accordance with guidelines which are published by the American Cancer Society or other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting specific data.

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*.

17. Major Diagnostic and Imaging - Outpatient

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

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

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

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

Benefits under this section include Mental Health Care Services to treat Severe Mental Illness, as required under Nevada insurance law.

Benefits include the following levels of care:

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

- Intensive Outpatient Treatment.
- Outpatient treatment.
- E-Visit.
- Biofeedback.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

Payment of Benefits for treatment relating solely to Mental Health Care and Substance-Related and Addictive Disorders Services will be made directly to the provider of Covered Health Care Services that provides the treatment if the provider:

- Is an out-of-Network provider, and
- Has obtained and delivered to us a written assignment of benefits pursuant to which the Covered Person has assigned to the provider the Covered Person's Benefits under the Policy of health insurance with regard to the treatment.

19. Palliative Care

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

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

20. Pharmaceutical Products - Outpatient

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

Benefits are provided for Pharmaceutical Products and the administration of the Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits for medication normally available by a prescription or order or refill are provided as described under *Outpatient Prescription Drug Benefits.*

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

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you 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 calling the telephone number on your ID card.

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

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

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

21. Physician's Office Services - Sickness and Injury

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

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

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

Covered Health Care Services include Genetic Counseling.

Benefits include:

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

As required under Nevada insurance law, Benefits include:

- Covered Health Care Services related to hormone replacement therapy.
- Covered Health Care Services related to contraceptives.

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*.

22. 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.

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

23. Preimplantation Genetic Testing (PGT) and Related Services

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

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

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

24. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* including colorectal exam screenings for Covered Persons 45 years of age or older.
    - Benefits for screenings that that do not have in effect a rating of "A" or "B" are described under *Lab, X-Ray and Diagnostic - Outpatient.*
    - Benefits for colorectal cancer screenings that do not have in effect a rating of "A" or "B" are described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

  Benefits include:

  - Well-woman visits, which include at least one visit per year beginning at 14 years of age.
  - Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than one year.
  - Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services.
  - Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases.
  - Prenatal screenings and tests as recommended by the *American College of Obstetricians and Gynecologists* or its successor organization.
  - Human papillomavirus (HPV) vaccine as recommended for vaccination by a competent authority. This includes deoxyribonucleic acid testing for high-risk strains of HPV every three years for women 30 years of age or older.
  - Coverage for prescription contraceptive drugs or devices approved by the *Food and Drug Administration (FDA).* Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include, but may be limited to the full range of *FDA* approved contraceptive methods without cost sharing. Benefits include at least one form of contraception in each of the methods (currently 18) that the *FDA* has identified in its current Birth Control Guide. These methods include, but are not limited to, hormonal methods, such as oral contraceptives, barrier methods such as prescription diaphragms and implanted devices, oral medications for emergency contraception and voluntary sterilization for women. The method of contraception used will be determined as prescribed or ordered by the provider of health care. Benefits include insertion of a device for contraception or removal of such device if the device was inserted while covered under the Policy. Benefits also include patient education and counseling relating to the initiation of the use of contraceptives and any necessary follow-up after initiating such use. Outpatient prescription oral contraceptives will be provided as described under the *Outpatient Prescription Drug Rider.*

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

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

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.
- With respect to all Covered Persons at an appropriate age and/or risk status. Benefits include:
  - Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care.

- Screening for depression.
- Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care.
- Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year.

You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force at* http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations and the *women's preventive services at* http://www.hrsa.gov/womensguidelines/ or on the Nevada DOI website at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/. If you do not have internet access, please call us at the telephone number on your ID card.

When there are material changes in the recommendations or guidelines that result in the cessation of providing Covered Health Care Services for preventive care services, at any time other than renewal, we will provide 60 days advance notice to the Covered Person.

25. Reconstructive Procedures

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

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

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

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

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

The first three years after mastectomy:

Benefits for reconstructive surgery, including complications relating to reconstructive surgery, performed while the patient is covered under the Policy, and within the first three years immediately following a mastectomy that was covered under the Policy, will be paid at the same level as would have been provided at the time of the mastectomy.

Benefits for reconstructive surgery performed within three years following a mastectomy that was covered under the Policy, while the patient is no longer covered by us under the Policy, will be paid at the same level as would have been provided at the time of the mastectomy except that no coverage will be provided for any complications relating to the reconstructive surgery.

26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.

- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

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

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

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

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. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

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

27. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital 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.

Benefits include colorectal cancer screening in accordance with the guidelines published by the *American Cancer Society.* 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.*

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

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

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

28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and Physician services received during the Inpatient Stay.

- Room and board in a Semi-private Room (a room with two or more beds).

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

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

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

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

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

29. Surgery - Outpatient

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

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

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

30. Temporomandibular Joint (TMJ) Services and Orthognathic Surgery

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

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

Non-surgical treatment including:

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

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

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

Benefits for surgical services include:

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

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

Benefits are also provided for orthognathic surgery.

31. Therapeutic Treatments - Outpatient

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

- Apherisis.
- Dialysis (both hemodialysis and peritoneal dialysis).
- Hyperbaric oxygen therapy.
- Intravenous chemotherapy.
- Radiation oncology.

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

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

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

32. Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

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

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

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

33. Urgent Care Center Services

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

34. Virtual Care Services

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

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

Benefits are available for the following:

- Mental Health Care Services and Substance-Related and Addictive Disorders Services, delivered through video, or through federally compliant secure messaging applications with, or supervised by, a properly qualified behavioral health provider.
- Urgent on-demand health care delivered through live video, or through federally compliant secure messaging applications for treatment of acute but non-emergency medical needs.

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

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

35. Vision Exams

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

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

Additional Benefits Required By Nevada Law

36. Autism Spectrum Disorder

Benefits are provided for Covered Health Care Services for the screening, diagnosis and treatment of Autism Spectrum Disorders for Covered Persons under 18 years of age or, if enrolled in high school, until age 22. Covered Health Care Services must be provided by a duly licensed Physician, psychologist or Behavior Analyst (including an Assistant Behavior Analyst, Registered Behavior Technician or State Certified Behavior Interventionist) or other provider that is supervised by the licensed Physician, psychologist or Behavior Analyst.

Covered Health Care Services include services provided by an early intervention agency.

Covered Health Care Services do not include services provided by a school for services delivered through early intervention or school services.

Please refer to the *Schedule of Benefits* for the specific limitation for *Applied Behavioral Analysis (ABA).*

37. Dental - Anesthesia and Hospital Facility Charges For Enrolled Dependent Children

Anesthesia and Hospital or facility charges in connection with dental procedures when hospitalization or general anesthesia is required when, in the opinion of the dentist, the Enrolled Dependent child meets any of the following criteria:

- Has a physical, mental or medically compromising condition.
- Has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy.
- Is extremely uncooperative, unmanageable or anxious.
- Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

The dentist must certify (or provide supporting documentation) that the criteria have been met.

38. Telehealth Services

Benefits for applicable Covered Health Care Services provided through telehealth are provided the same as other Covered Health Care Services.

“Telehealth” means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including facsimile or electronic mail.

For services provided through telehealth, we will not:

- Require you to establish a relationship in person.
- Refuse to provide coverage because of the distant site from which a provider delivers services through telehealth.
- Refuse to provide coverage because of the originating site at which you receive services through telehealth.

Prior authorization is not required for any service provided through telehealth that is not required for the service when provided in person.

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

"Distant site" means the location of the site where a telehealth provider of health care is providing Telehealth services to a patient located at an originating site.

"Originating site" means the location of the site where a patient is receiving telehealth services from a provider of health care located at a distant site.

Telehealth services do not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under *Virtual Care Services.*

Benefits are also provided for Remote Physiologic Monitoring.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

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

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services - Accident and Medical* in *Section 1: Covered Health Care Services.* This exclusion does not apply to dental anesthesia or Hospital charges for which Benefits are provided as described *under Dental - Anesthesia and Hospital Facility Charges for Enrolled Dependent Children in Section 1: Covered Health Care Services.*

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

   Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident and Medical* in *Section 1: Covered Health Care Services.*

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

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

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Trusses.
   - Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech.

5. Communication aids or devices; equipment to create, replace or augment communication abilities including speech processors, receivers, and communication boards; or computer or electronic assisted communication.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
9. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill except as provided as described under *Outpatient Prescription Drug Benefits*.
2. Self-administered or self-infused medications except as provided as described under *Outpatient Prescription Drug Benefits*. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy except as provided as described under *Outpatient Prescription Drug Benefits*.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
12. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
13. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

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

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

F. Foot Care

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

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

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
    - Abdominoplasty.
    - Blepharoplasty.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.

- Facial bone remodeling for facial feminizations.
- Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Ace bandages.
   - Gauze and dressings.
   - Bandages and tape.
   - Antiseptics.
   - Diapers and incontinence supplies.

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

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

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

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic*

and Statistical Manual of the American Psychiatric Association. This exclusion does not apply to conditions defined as *Severe Mental Illness in Section 9: Defined Terms.*

2. *Intense Early Intervention Using Behavioral Therapy (IEIBT)* and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorder.
3. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. This exclusion does not apply to conditions defined as *Severe Mental Illness in Section 9: Defined Terms.*
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM)* criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
10. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

J. Nutrition

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

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Safety equipment.
   - Treadmills.
   - Vehicle modifications such as van lifts.
   - Video players.
   - Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:

   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.

- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
- Treatments for hair loss.
- Varicose vein treatment of the lower extremities.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs (scalp/cranial hair prostheses) except for Covered Persons with scalp/head wound, burns, Injuries, alopecia aerate, cancer, and undergoing chemotherapy or radiation therapy.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
5. Habilitative services for maintenance/preventive treatment.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. 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.
8. Services for the diagnosis and treatment of TMJ for those methods of treatment which are recognized as dental procedures, including but not limited to, the extraction of teeth and the application of orthodontic devices and splints.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
10. Upper and lower jawbone surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment. This exclusion does not apply to surgery for which Benefits are provided as

described under *Temporomandibular Joint (TMJ) Services and Orthognathic Surgery* in *Section 1: Covered Health Care Services*.

11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
13. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Care Services.
14. Helicobacter pylori (H. pylori) serologic testing.
15. Intracellular micronutrient testing.
16. Chelation therapy, except to treat heavy metal poisoning.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services ordered or delivered by a Christian Science practitioner.
4. Service performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

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

    This exclusion does not apply to mammography.

O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described *under Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services in Section 1: Covered Health Care Services.*
2. The following services related to a Gestational Carrier or Surrogate:

    - All costs related to reproductive techniques including:
        - Assisted reproductive technology.
        - Artificial insemination.
        - Intrauterine insemination.
        - Obtaining and transferring embryo(s).

- Preimplantation Genetic Testing (PGT) and related services.

- Health care services including:
  - Inpatient or outpatient prenatal care and/or preventive care.
  - Screenings and/or diagnostic testing.
  - Delivery and post-natal care.

  The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

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

P. Services Provided under another Plan

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

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

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

R. Travel

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

S. Types of Care

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

T. Vision and Hearing

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

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

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

U. All Other Exclusions

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

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

2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption, or as the result of incarceration.
   - 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 the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. This exclusion does not apply to breast reconstruction following mastectomy within three years of the mastectomy as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Co-payments or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy and other coroner services and transportation services for a corpse.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

- Missed appointments.
- Completion of claims forms.
- Record processing.

13. Over-the-counter self-administered home diagnostic tests, including HIV and Pregnancy tests.
14. Retail genetic tests direct to consumer.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

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

Coverage for a newborn child, adopted child or a child placed for adoption begins on the date of birth, adoption or placement for adoption and will remain in effect for 31 days. If payment of additional Premium is required in order to provide coverage for the child, the Subscriber must notify us of the event and pay any additional required Premium within 31 days of the event in order to continue coverage beyond the initial 31-day period.

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

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

- Registering a Domestic Partner.

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

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

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above. Coverage for a newborn child, adopted child or a child placed for adoption begins on the date of birth, adoption or placement for adoption and will remain in effect for 31 days. If payment of additional Premium is required in order to provide coverage for the child, the Subscriber must notify us of the event and pay any additional required Premium within 31 days of the event in order to continue coverage beyond the initial 31day period.

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 60 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

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

Coverage for a Disabled Dependent Child

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

- The 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 Subscriber for support.

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

We may require you to furnish us with reasonable proof of the disability and financial dependence within 31 days of the date coverage would have ended because the child reached a certain age. Examples of reasonable proof may include medical certification from a Physician, social security documentation identifying proof of disability, or the Subscriber's most recent federal income tax return that verifies the Enrolled Dependent is in fact a Dependent of the Subscriber. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

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

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

Continuation of Coverage

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

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

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

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

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

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

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, call the telephone number on your ID card. Nevada state law prohibits providers, who fail to submit any claim for payment, from requesting or requiring payment from you for any portion of the charge beyond what you would have been required to pay if the provider had submitted the claim for payment. This does not apply if the information you provide to the provider is inaccurate, outdated, or causes the provider to submit the claim in a manner that violates the terms of the Health Care Plan. However, you are required to pay any required Co-payments to a Network provider.

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

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

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

Required Information

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

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name, address, tax identification number, NPI number and license number, if available, of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).
- Proof of payment may be requested to substantiate your claim but is not required upon initial submission.

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

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

OptumRx

P.O. Box 650629

Dallas, TX 75265-0629

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information. If an approved claim is not paid within 30 days after it is approved, we will pay interest on the claim at the rate required by law. Interest is calculated from 30 days after the date on which the claim is approved until the date the claim is paid.

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

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

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

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

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

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

Call the telephone number on your ID card if you have a question. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number on your ID card if you have a complaint. Representatives are available to take your call during regular business hours, Monday through Friday.

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can call the telephone number on your ID card to request an appeal filing form.

The appeal filing form should include:

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

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. We will provide written notice of the denial within ten business days.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to

reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination. "Adverse determination" means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Appeals Determinations

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

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

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

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

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

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- You may obtain an expedited appeals process in urgent cases and contact the Office of Consumer Health Assistance ("OCHA") at:

Office of Consumer Health Assistance
Governor's Consumer Health Advocate
555 East Washington Ave., #4800

Las Vegas, NV 89101
Phone: (702) 486-3587
Toll Free:(888) 333-1597

http://dhhs.nv.gov/Programs/CHA/ (website)
cha@govcha.state.nv.us (email)

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

Denial of Experimental, Investigational or Unproven Services

If we deny Benefits for a medical procedure or plan of treatment as being Experimental or Investigational Services or Unproven Services and those services are for a Covered Person with a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), we will provide you with written notification of all of the following:

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.
- The specific medical and scientific reasons for the denial and specific references to pertinent Policy provisions upon which the denial is based.
- A description of the alternative medical procedures or treatments covered by the Policy, if any.
- A description of the process of external review explaining how you or your representative can appeal the denial and take part in the review. An external review will be provided to the Covered Person within 30 calendar days following the receipt of a request for external review. An expedited review may be held within 5 business days at the request of the treating Physician.

Standard External Review

After we receive a notice from OCHA of a request for external review, we will make a preliminary determination of eligibility for the review within 5 business days of the receipt of the request. We will notify OCHA and the Covered Person within one business day after the completion of the review whether the request is eligible for external review. OCHA will assign the external review to an External Review Organization ("ERO"), who will conduct the review.

Expedited External Review

The treating Physician may submit an oral request if he/she can certify in writing that the treatment would be significantly less effective if not promptly initiated. OCHA will notify us of the request for an expedited external review. We will find out if the request meets the requirements for review and notify OCHA and the Covered Person of that determination. OCHA can overturn our determination that the request is ineligible. OCHA will assign an ERO to conduct the expedited external review.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent External Review from the OCHA at no cost to you. You, your provider, or authorized representative may request an external review if we have not issued a written decision within 30 days on an internal grievance.

You also have the right to request and expedited "internal" grievance and an expedited external review simultaneously when the service or treatment is experimental or investigational and the treating physician certifies in writing that the service or treatment would be less effective if not promptly initiated.

Standard External Review

Within five business days after receiving the request for external review, OCHA will notify you, other interested parties and us that a request for external review has been filed. OCHA will identify, assign, and provide all documents relating to the adverse determination to the ERO. The ERO will coordinate with you

and us for additional information needed to conduct the review. Within 15 days of completing the review, the ERO will submit a copy of its determination to you.

Expedited External Review

We will approve or deny a request for an external review of a final adverse determination in an expedited manner not later than 72 hours after we receive proof from the Covered Person's provider of health care that failure to proceed in an expedited manner may jeopardize the life or health of the insured.

OCHA will approve or deny a request for an expedited external review within 72 hours after it has determined that the adverse determination concerns:

- An admission, availability of care, continued stay or health care service for which the Covered Person received emergency services but has not been discharged from the facility providing the care; or
- Failure to proceed in an expedited manner may jeopardize the life or health of the Covered Person or the ability of the covered person to regain maximum function.

Upon a determination that the request is eligible for an expedited external review, OCHA will assign an ERO within one working day after approving the request. The ERO will coordinate with us for all documents and information we used to make the adverse determination. Within 48 hours the ERO will notify the Covered Person, his/her physician, and us of its determination by telephone with a follow up in writing.

If the determination of the ERO is in favor of the Covered Person, the determination is final, conclusive, and binding.

External Review Timeframes

- A physician, Covered Person or authorized representative, may submit a request for an External Review within four months after receiving notice of the final adverse determination.
- Within five days of receiving the request we will notify the physician, the Covered Person or authorized representative, the agent who performed the review, and the Office for Consumer Health Assistance that the request was filed.
- The Office for Consumer Health Assistance will assign an External Review Organization and notify us.
- Within 5 days of receiving notification we will provide all documents and materials relating to the final adverse determination including:
    - Medical records;
    - Copy of provision of the Health Care Plan upon which the final adverse determination was based;
    - Documents used by us to make the final adverse determination;
    - Reasons for the final adverse determination; and
    - A list that specifies each provider of health care who has provided health care to the insured and medical record of the provider of health care relating to the external review.
    - Within 5 days of receiving the request for external review from the ERO will review the documents and material and notify the consumer, physician and us if any additional information is required.
    - The ERO is to make a determination within 15 days of receiving all information needed for the review.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

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

2. Plan does not include: franchise insurance, 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; medical benefits under group or individual automobile contracts; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is

secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse or Domestic Partner.

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

(d) The Plan covering the non-Custodial Parent's spouse or Domestic Partner.

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

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

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

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

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

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

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

7. If a Covered Person is covered by a stand-alone dental benefit and a policy of health insurance, generally the stand-alone dental benefit is the primary policy and the claim must be first submitted to the health insurer that issued the stand-alone dental benefit.

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.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

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

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

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

Notice

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

Statements by Group or Subscriber

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

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

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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.

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.

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

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

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

Subrogation Example:

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

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

Reimbursement Example:

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers’ compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by us.
- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.

- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

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

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

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

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

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

Is There a Limitation of Action?

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

What Is the Entire Policy?

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

Section 9: Defined Terms

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

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

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

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

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

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

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

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

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

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

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 the Recognized Amounts, when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Applied Behavioral Analysis - the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including without limitation the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Assistant Behavior Analyst - a person who holds current certification as a board certified Assistant Behavior Analyst issued by the *Behavior Analyst Certification Board, Inc*., or any successor in interest to that organization, and is licensed as an Assistant Behavior Analyst by the *Division*.

Autism Spectrum Disorder - a condition that meets the diagnostic criteria for Autism Spectrum Disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association* or the edition of the Manual that was in effect at the time the condition was diagnosed or determined.

Behavior Analyst - a person who holds current certification as a board certified Behavior Analyst issued by the *Behavior Analyst Certification Board, Inc.,* or any successor in interest to that organization, and is licensed as such by the *Division*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child, including a newborn child from the moment of birth.
- A stepchild.
- A legally adopted child beginning from the date the adoption becomes effective if the child was not placed in the home before adoption.
- A child placed in foster care.
- A child placed for adoption beginning from the moment of placement as certified by the public or private agency making the placement.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

  Pursuant to a court order, a Dependent includes a child who is related to the Subscriber without regard to any of the following facts:

  - The child does not reside with the Subscriber.
  - The child is born out of wedlock.
  - The child is not claimed as a dependent on the Subscriber's federal or state income tax.

  When a child is enrolled in a plan of the noncustodial parent or a parent sharing custody or temporary control of the child, we will:

  - Provide the custodial parent with any information necessary to obtain Benefits and services for the child under this Policy.
  - Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the noncustodial parent.
  - Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the state agency responsible for the administration of Medicaid.

  If the Subscriber or Dependent spouse or Domestic Partner is required by a court or administrative order to provide health care coverage for the Subscriber or Dependent spouse's child, the child, if otherwise eligible for coverage, will be able to be enrolled regardless of any enrollment season restriction. We will enroll the child upon application for enrollment by the Subscriber, the Dependent spouse, the state agency responsible for the administration of Medicaid, or a state child support enforcement agency.

  We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

  - The Group receives satisfactory written evidence that the order requiring coverage is no longer in effect.
  - The Group receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of disenrollment under this policy.
  - The Group has eliminated dependent health coverage for all its Subscribers.
  - The Subscriber is no longer eligible for coverage.

The following conditions apply:

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

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

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

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

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

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

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

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

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

Domestic Partner - persons who have registered a valid Domestic Partnership and when two persons who satisfy the following requirements:

- Both persons have a common residence ("common residence" means a residence shared by both Domestic Partners on at least a part-time basis, irrespective of whether: (1) ownership of the residence or the right to occupy the residence is in the name of only one of the Domestic Partners; and (2) one or both of the domestic partners owns or occupies an additional residence).
- Neither person is married or a member of another Domestic Partnership;
- The two persons are not related by blood in a way that would prevent them from being married to each other in this State;
- Both persons are at least 18 years of age; and
- Both persons are competent to consent to the Domestic Partnership.

Domestic Partnership - the social contract between two persons registered in the State of Nevada that meet the Domestic Partners requirements described above and:

- File with the *Office of the Secretary of State,* on a form prescribed by the *Secretary of State,* a signed and notarized statement declaring that both persons:
  - Have chosen to share one another's lives in an intimate and committed relationship of mutual caring; and
  - Desire of their own free will to enter into a Domestic Partnership; and

- Pay to the *Office of the Secretary of State* a reasonable filing fee established by the Secretary of State.

The definition of Domestic Partnership also includes:

- A legal union of two persons that was validly formed in another jurisdiction that is substantially equivalent to a Domestic Partnership in the State of Nevada regardless of whether the union bears the name of a Domestic Partnership or is registered in the State of Nevada.

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

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

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

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

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

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act ,* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an

available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e) Any other conditions as specified by the Secretary.

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

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

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

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

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

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- Services subject to a *Surest Coverage with Evidence Development Policy (CED Policy reference)*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

Health Benefit Plan - a Policy, contract, *Certificate* or agreement offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. Except as otherwise provided in this section, the term includes catastrophic health insurance policies and a policy that pays on a cost-incurred basis. The term does not include:

- Coverage that is only for accident or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Coverage for medical payments under a policy of automobile insurance;
- Credit insurance;
- Coverage for on-site medical clinics;
- Other similar insurance coverage specified pursuant to the *Health Insurance Portability and Accountability Act of 1996, Public Law 104-191,* under which benefits for medical care are secondary or incidental to other insurance benefits;
    - Coverage under a short-term health insurance policy; and
    - Coverage under a blanket student accident and health insurance policy.
- The term does not include the following benefits if the benefits are provided under a separate Policy, *Certificate* or contract of insurance or are otherwise not an integral part of a health benefit plan:
    - Limited-scope dental or vision benefits;

- Benefits for long-term care, nursing home care, home health care or community-based care, or any combination thereof; and
- Such other similar benefits as are specified in any federal regulations adopted pursuant to the *Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.*

- The term does not include the following benefits if the benefits are provided under a separate Policy, *Certificate* or contract, there is no coordination between the provisions of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid for a claim without regard to whether benefits are provided for such a claim under any group health plan maintained by the same plan sponsor:
  - Coverage that is only for a specified disease or illness; and
  - Hospital indemnity or other fixed indemnity insurance.
- The term does not include any of the following, if offered as a separate Policy, *Certificate* or contract of insurance:
  - Medicare supplemental health insurance as defined in section 1882(g)(1) of the *Social Security Act, 42 U.S.C. § 1395ss*, as that section existed on July 16, 1997;
  - Coverage supplemental to the coverage provided pursuant to the *Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. §§ 1071 et seq.;* and
  - Similar supplemental coverage provided under a group health plan.

Health Care Plan - a Policy, contract, *Certificate* or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

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

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

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

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

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

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

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

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

- A long term acute rehabilitation center,

- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

Level 1 Procedure - category of minor procedures typically performed in an outpatient office setting.

Level 2 Procedure - category of minor surgeries and procedures or services typically performed in an outpatient Hospital setting.

Level 3 Procedure - category of major surgeries and procedures typically performed in an outpatient or inpatient Hospital setting.

Level 4 Procedure - category of major surgeries typically performed in an inpatient Hospital setting.

Level 5 Procedure - category of more complex major surgeries typically performed in an inpatient Hospital setting.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee:

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

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical

community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

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

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

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

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

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

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

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

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.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

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

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - 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, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- Group *Application*.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

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

Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M: For monogenic disorder (formerly single-gene PGD).
- PGT-SR: For structural rearrangements (formerly chromosomal PGD)**.**

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

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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

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

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount - the amount which the Co-payment and any 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 Health 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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health care professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Registered Behavior Technician - a person who is registered as such by the Division and provides behavioral therapy under the supervision of:

- A licensed psychologist;
- A licensed Behavior Analyst; or
- A licensed Assistant Behavior Analyst.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

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

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Severe Mental Illness - any of the following Mental Illnesses that are biologically based and for which diagnostic criteria are prescribed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:* schizophrenia; schizoaffective disorder; bipolar disorder; major depressive disorders; panic disorder; obsessive-compulsive disorder.

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

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

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

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

State Certified Behavior Interventionist - a person who is registered as such by the Division and provides behavioral therapy under the supervision of:

- A licensed psychologist;
- A licensed Behavior Analyst; or
- A licensed Assistant Behavior Analyst.

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

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

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

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to

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

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

Section 10: Outpatient Prescription Drug Benefits

NOTE: The Coordination of Benefits provision in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products. Benefits for Prescription Drug Products will not be coordinated with those of any other health coverage plan.

Coverage Policies and Guidelines

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

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

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

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

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please visit benefits.surest.com or call the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and Ancillary Charge.

Submit your claim to:

Optum Rx

P.O. Box 650629

Dallas, TX 75265-0629

Designated Pharmacies

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

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

Smart Fill Program - Split Fill

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

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Benefit*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

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

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by visiting benefits.surest.com or calling the telephone number on your ID card.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. You may access information on these procedures by visiting benefits.surest.com or calling the telephone number on your ID card.

Prescription Drug Products Exception Process

You and your provider may request an exception for a covered prescribed drug that was previously approved for a medically necessary medical condition, if:

- Your provider determines that, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate; and
- Your provider determines that the currently approved and prescribed drug is considered safe and effective for treating the medically necessary medical condition.

We may require the provider to submit clinical documentation as part of the exception request. Please call us at the telephone number on your ID card to request an exception.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by visiting benefits.surest.com or calling 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 other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments.

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

Benefits for early refills for prescription eye drops are available:

- After 21 days or more but before 30 days after receiving any 30-day supply of the product;
- After 42 days or more but before 60 days after receiving any 60-day supply of the product; or
- After 63 days or more but before 90 days after receiving any 90-day supply of the product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

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

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

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

Please visit benefits.surest.com or call the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Exclusions

Exclusions from coverage listed in *Section 2: Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can visit benefits.surest.com or call the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration (FDA)* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
    - The acceptable standard medical reference compendia are the following:
        - The *American Hospital Formulary Service Drug Information, a publication of the American Society of Health System Pharmacists.*
        - *The National Comprehensive Cancer Network Drugs and Biologics Compendium.*
        - *Thomson Micromedex Compendium DRUGDEX.*
        - *Elsevier Gold Standard's Clinical Pharmacology Compendium.*
        - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services.*
    - Medical literature may be accepted if all of the following apply:
        - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

- No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
- The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors,* or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to *Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).*

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided under Pharmaceutical Products in *Section 1: Covered Health Care Services*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other 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 under *Durable Medical Equipment, Orthotics, Prosthetic Devices, and Supplies* in *Section 1: Covered Health Care Services*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
13. Certain unit dose packaging or repackagers of Prescription Drug Products.
14. Medications used for cosmetic or convenience purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and for Preimplantation Genetic Testing (PGT) as described in this *Certificate*.
18. Certain Prescription Drug Products for tobacco cessation.
19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.

20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.

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

22. 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.

23. A particular Therapeutic Class or Therapeutic Classes. Please contact us at benefits.surest.com or the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.

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

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

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

27. 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).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

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

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. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Defined Terms

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

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

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

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

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

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

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

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medication may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at benefits.surest.com or the telephone number on your ID card.

Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our review and change from time to time and varies by Therapeutic Class.

Network Pharmacy - a pharmacy that has:

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

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

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

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment,) as required by applicable law under any of the following:

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

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by visiting benefits.surest.com or calling the telephone number on your ID card.

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

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

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. 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 visiting benefits.surest.com or calling the telephone number on your ID card for the most up-to-date tier placement.

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

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- Self-administered hormonal contraceptives, provided without a prescription, when a Pharmacist complies with the providing requirements protocols of the State Board of Pharmacy. A "self-administered hormonal contraceptive" includes, without limitation, an oral contraceptive, a vaginal contraceptive ring, a contraceptive patch and any other method of hormonal contraceptive identified by the standing order issued by the Chief Medical Officer or his/her designee.
- HIV preventative drugs, subject to reasonable management techniques as determined by Nevada state law, when prescribed by a participating Pharmacist.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and

- glucose meters, including continuous glucose monitors.

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*. Specialty Prescription Drug Products include orally administered anticancer medications used to kill or slow the growth of cancerous cells. You may access a complete list of Specialty Prescription Drug Products by visiting benefits.surest.com or calling the telephone number on your ID card.

Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.

Therapeutic Class Charge - a charge, in addition to the Co-payment, that you must pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount.

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

- The Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed.
- The Maximum Allowable Amount for the Therapeutic Class.

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

Therapeutically Equivalent Charge - a charge, in addition to the Co-payment, that you must pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount.

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

- The Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed.
- The Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.

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

Your Right to Request an Exclusion Exception

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

Urgent Requests

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

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on

your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

Expedited External Review

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

Surest Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

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

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

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Ground and Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

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

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

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

Does Prior Authorization Apply?

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

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

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining required prior authorization or pre-admission notification before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have

been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

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

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

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

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits.	***Network and Out-of-Network*** No Annual Deductible

Payment Term And Description	Amounts
Out-of-Pocket Limit	
The maximum you pay per year for Co-payments. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under *Outpatient Prescription Drug Benefits.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit. Any amount that you pay for Covered Health Care Services that is applied to the Network Out-of-Pocket Limit will also be applied to the out-of-Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services that is applied to the out-of-Network Out-of-Pocket Limit will not be applied to the Network Out-of-Pocket Limit.	***Network*** $4,000 per Covered Person. $4,000 per Covered Person, not to exceed $8,000 for all Covered Persons in a family. ***Out-of-Network*** $8,000 per Covered Person. $8,000 per Covered Person, not to exceed $16,000 for all Covered Persons in a family.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive Covered Health Care Services. Co-payments are shown as the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount, when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. In the Benefits table below, some Co-payments are listed as a range. Providers are assigned Co-payments within the range based on treatment outcomes and cost information that identifies Network providers that provide cost-efficient care. For Benefits listed with a Co-payment range or with a Co-payment maximum, you should visit benefits.surest.com, check the Surest app, or call the telephone number on your ID card for current provider specific Co-payment information.	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
1. Acupuncture Services			
Limited to 60 treatments per year. Limits above do not apply for the treatment of Mental Illness or substance-related and addictive disorders.	***Network*** $30 per visit ***Out-of-Network*** $90 per visit	 Yes Yes	 No No
2. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below	***Network*** *Ground Ambulance* $160 per transport	Yes	No

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

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

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
under *Allowed Amounts* in this *Schedule of Benefits.*			
	Air Ambulance $160 per transport	Yes	No
	Out-of-Network		
	Ground Ambulance $160 per transport	Yes	No
	Air Ambulance Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	***Network*** *Ground Ambulance* $160 per transport	Yes	No
	Air Ambulance $160 per transport	Yes	No

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

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

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Out-of-Network *Ground Ambulance* $160 per transport *Air Ambulance* Same as Network	Yes Same as Network	No Same as Network
3. Cellular and Gene Therapy			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	Covered Health Care Service category in this *Schedule of Benefits.*		
4. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
5. Dental Services - Accident and Medical			
	Network *Oral Surgery* $250 per visit	Yes	No

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	All Other Services		
	Inpatient		
	$1,600 per Inpatient Stay	Yes	No
	Outpatient Hospital		
	*$75 to $500 per visit	Yes	No
	Outpatient Office Visit		
	*$10 to $65 per visit	Yes	No
	Out-of-Network		
	Oral Surgery		
	$750 per visit	Yes	No
	All Other Services		
	Inpatient		
	$4,800 per Inpatient Stay	Yes	No
	Outpatient Hospital	Yes	No
	$1,500 per visit		
	Outpatient Office Visit		
	$195 per visit	Yes	No
6. Diabetes Services			

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

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care Limited to one pair of therapeutic, custom-molded shoes, when prescribed by a Physician for the treatment of diabetes, per year.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME),*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* and in *Outpatient Prescription Drug Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
Orthotics, Prosthetic Devices, and Supplies.	***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* and in the *Outpatient Prescription Drug Schedule of Benefits.*		
7. Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME, prosthetic devices, or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
To determine the tiers to which DME, orthotics, prosthetic devices, and supplies are assigned, visit benefits.surest.com or call the telephone number on your ID card. Scalp/cranial hair prosthesis (wigs) are limited to one - three per year.	***Network*** *Tier 1* $0 per item *Tier 2* $20 per item	Yes Yes	No No

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Cataract surgery or aphakia is limited to one eyeglasses frame and one pair of lenses, or one pair of contact lenses, or one year supply of disposable contact lenses. Note: returning home with Durable Medical Equipment, such as crutches, after an appointment with a health care provider or from an outpatient procedure or Inpatient Stay, may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to.	*Tier 3* $40 per item *Tier 4* $60 per item *Tier 5* $80 per item *Tier 6* $100 per item *Tier 7* $150 per item *Tier 8* $200 per item *Tier 9* $250 per item *Tier 10* $300 per item *Tier 11* $400 per item *Tier 12*	Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No No

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	$500 per item	Yes	No
	Out-of-Network		
	Tier 1		
	$20 per item	Yes	No
	Tier 2		
	$40 per item	Yes	No
	Tier 3		
	$80 per item	Yes	No
	Tier 4		
	$120 per item	Yes	No
	Tier 5		
	$160 per item	Yes	No
	Tier 6		
	$200 per item	Yes	No
	Tier 7		
	$300 per item	Yes	No
	Tier 8		
	$400 per item	Yes	No
	Tier 9		

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	\$500 per item *Tier 10* \$600 per item *Tier 11* \$800 per item *Tier 12* \$1,000 per item	Yes Yes Yes Yes	No No No No
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the	***Network*** \$325 per visit.	Yes	No

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
continued stay is determined to be a Covered Health Care Service.			
If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.* Note: returning home with Durable Medical Equipment, such as crutches, after an Emergency room visit may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	***Out-of-Network*** Same as Network	Same as Network	Same as Network

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
9. Enteral Nutrition			
In addition to the Co-payment stated in this section, you will also be responsible for the Co-payment stated under the *Home Health Care* Benefit if you also receive services from a Home Health Agency.	***Network*** $100 per 30-day supply	Yes	No
	Out-of-Network $200 per 30-day supply	Yes	No
10. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Limited to $10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under *Preimplantation Genetic Testing (PGT) and Related Services.* Benefits are further limited to one cycle of fertility preservation for	***Network*** $100 per visit	Yes	No

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.			
	Out-of-Network $200 per visit	Yes	No
11. Gender Dysphoria			

Prior Authorization Requirement for Surgical Treatment

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

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*

	Network

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Schedule of Benefits.*		
12. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Skilled Nursing Facility/Inpatient Rehabilitation Services.	Covered Health Care Service category in this *Schedule of Benefits*.		
Outpatient therapies: • Manipulative Treatment. • Physical therapy. • Occupational therapy. • Speech therapy. • Cognitive therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	*Outpatient* *Manipulative Treatment* $15 per visit	Yes	No
Note: returning home with Durable Medical Equipment, such as a walker, following habilitative services may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and*	*Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders* $10 per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Supplies category in this *Schedule of Benefits*.	*Occupational Therapy for All Other Conditions* *$10 to $60 per visit	Yes	No
	Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $10 per visit	Yes	No
	Physical Therapy for All Other Conditions *$10 to $50 per visit	Yes	No
	Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $10 per visit	Yes	No
	Speech Therapy for All Other Conditions	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	*$10 to $60 per visit *Post-cochlear Implant Aural Therapy* *$10 to $65 per visit *Cognitive Therapy* *$10 to $60 per visit	Yes Yes	No No
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient *Manipulative Treatment* $45 per treatment *Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders* $30 per visit	Yes Yes	No No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Occupational Therapy for All Other Conditions $180 per visit	Yes	No
	Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $30 per visit	Yes	No
	Physical Therapy for All Other Conditions $150 per visit	Yes	No
	Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $30 per visit	Yes	No
	Speech Therapy for All Other Conditions $180 per visit	Yes	No
	Post-cochlear Implant Aural Therapy		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	$195 per visit	Yes	No
	Cognitive Therapy $180 per visit	Yes	No
13. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Rehabilitative/Habilitative Services provided in the home by other than a Home Health Agency Limit will be the same as, and combined with, those stated under *Habilitative Services* and *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	***Network*** *Rehabilitative/Habilitative Services provided in the Home* $30 per visit	Yes	No
	Home Health Care Visit for Enteral Feeding $20 per visit	Yes	No
All Other Services	*Home Health Care Visit for All Other Services*	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Limited to 120 visits per year. One visit equals up to four hours of skilled care services. Visit limits above do not include any service which is billed only for the administration of intravenous infusion. Visit limits above do not apply for the treatment of Mental Illness and substance-related and addictive disorders. In addition to the Co-payment stated in this section, you will also be responsible for the Co-payment stated under the *Enteral Nutrition* Benefit for enteral formulas and low protein modified food products.	$30 per visit		
	Out-of-Network *Rehabilitative/Habilitative Services provided in the Home* $90 per visit	Yes	No
	Home Health Care Visit for Enteral Feeding	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	$40 per visit *Home Health Care Visit for All Other Services* $90 per visit	Yes	No
14. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network *Home Visit* $30 per visit	Yes	No
	Inpatient $1,600 per Inpatient Stay	Yes	No
	Out-of-Network *Home Visit* $90 per visit	Yes	No

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	Inpatient $4,800 per Inpatient Stay	Yes	No
15. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Note: returning home with Durable Medical Equipment, such as crutches, following an inpatient Hospital admission may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	***Network*** *Level 3 Procedure* *$150 to $2,500 per Inpatient Stay	Yes	No
	Level 4 Procedure *$150 to $2,500 per Inpatient Stay	Yes	No

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	Level 5 Procedure *$850 to $2,500 per Inpatient Stay	Yes	No
	All Other Inpatient Stays $1,600 per Inpatient Stay	Yes	No
	Out-of-Network *Level 3 Procedure* **$7,000 per visit	Yes	No
	Level 4 Procedure **$7,000 per Inpatient Stay	Yes	No
	Level 5 Procedure **$7,000 per visit	Yes	No
	All Other Inpatient Stays $4,800 per Inpatient Stay	Yes	No
16. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, including BRCA testing and sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you do not			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient	***Network***		
	Genetic Testing, other than BRCA $120 per visit	Yes	No
	Allergy Testing $70 per visit	Yes	No
	All Other Lab Testing, including BRCA None per visit	Yes	No
	Out-of-Network		
	Genetic Testing, other than BRCA $360 per visit	Yes	No
	Allergy Testing $210 per visit	Yes	No
	All Other Lab Testing, including BRCA		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	None per visit	Yes	No
X-Ray and Diagnostic Ultrasound - Outpatient If imaging is performed on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, more than one Co-payment may apply. If more than one type of imaging is performed, such as an x-ray and ultrasound, on the same date of service, more than one Co-payment may apply.	***Network*** None per visit	Yes	No
	Out-of-Network None per visit	Yes	No
All Other Diagnostic Testing - Outpatient If more than one type of diagnostic testing is performed, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one Co-payment may apply.	***Network*** *Transesophageal Echocardiogram* *$300 to $1,400 per visit	Yes	No
	Sleep Study - Home	Yes	No

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	$80 per visit *Sleep Study - Facility* $100 to $600 per visit *All Other Diagnostic Testing - Outpatient* *$20 to $600 per visit ***Out-of-Network*** *Transesophageal Echocardiogram* $4,200 per visit *Sleep Study - Home* $240 per visit *Sleep Study - Facility* $1,800 per visit *All Other Diagnostic Testing - Outpatient* ** $1,800 per visit	Yes Yes Yes Yes Yes Yes	No No No No No No
17. Major Diagnostic and Imaging - Outpatient			

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, angiography and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
If imaging is performed on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, more than one Co-payment may apply. If more than one type of imaging is performed, such as an MRI and CT scan, on the same date of service, more than one Co-payment may apply.	***Network*** *$75 to $500 per visit	Yes	No
	Out-of-Network **$1,500 per visit	Yes	No
18. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network		
	Inpatient Hospital		
	$1,600 per Inpatient Stay	Yes	No
	Residential Treatment		
	$1,200 per Inpatient Stay	Yes	No
	Outpatient		
	Office Visit - In-Person		
	$10 per visit	Yes	No
	Office Visit - Telehealth		
	$10 per visit	Yes	No
	Biofeedback		
	$10 per visit	Yes	No
	Applied Behavioral Analysis (ABA)		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	$10 per visit	Yes	No
	E-Visit/Telephone Visit $10 per visit	Yes	No
	Substance-Related and Addictive Disorders Medication Management $5 per visit	Yes	No
	Partial Hospitalization $70 per visit	Yes	No
	Electroconvulsive Therapy $70 per visit	Yes	No
	Intensive Outpatient Treatment $70 per visit	Yes	No
	Subacute Detoxification Care $70 per visit	Yes	No
	Transcranial Magnetic Stimulation (TMS) Therapy		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	$75 per visit	Yes	No
	All Other Outpatient Services $70 per visit	Yes	No
	Out-of-Network		
	Inpatient Hospital $4,800 per Inpatient Stay	Yes	No
	Residential Treatment $3,600 per Inpatient Stay	Yes	No
	Outpatient *Office Visit - In-Person* $100 per visit	Yes	No
	Office Visit - Telehealth $100 per visit	Yes	No
	Biofeedback $100 per visit	Yes	No
	Applied Behavioral Analysis (ABA) $100 per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	E-Visit/Telephone Visit $195 per visit	Yes	No
	Substance-Related and Addictive Disorders Medication Therapy $15 per visit	Yes	No
	Partial Hospitalization $210 per visit	Yes	No
	Electroconvulsive Therapy $210 per visit	Yes	No
	Intensive Outpatient Treatment $210 per visit	Yes	No
	Subacute Detoxification Care $210 per visit	Yes	No
	Transcranial Magnetic Stimulation (TMS) Therapy $225 per visit	Yes	No

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	All Other Outpatient Services $210 per visit	Yes	No
19. Palliative Care			
Note: returning home with Durable Medical Equipment, such as a walker, following palliative care may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
20. Pharmaceutical Products - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon			

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. For Out-of-Network Benefits, you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. You may find out whether a particular Pharmaceutical Product requires prior authorization by visiting benefits.surest.com or calling the telephone number on your ID card.			
Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical Products. Your Co-payment may vary when you use a coupon. Contact benefits.surest.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products and the applicable Co-payment.	***Network*** *None to $1,800 per visit	Yes	No
	Out-of-Network **$5,400 per visit	Yes	No
21. Physician's Office Services - Sickness and Injury			
Note: returning home with Durable Medical Equipment, such as crutches, following an office visit	***Network***		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*. In addition to the Co-payment stated in this section, the Co-payment for following services also apply when the Covered Health Care Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*	*Primary Care Physician/Specialist* *Office Visit - In-Person* *\$10 to \$65 per visit *Telehealth Visit* *\$10 to \$65 per visit *Visit in the Home* \$25 per visit *Convenience Care/Retail* \$10 per visit *Allergy Injections* \$0 per visit *Biofeedback* \$45 per visit *E-Visit/Telephone Visit* \$10 per visit *Anticoagulant Management* \$15 per visit	Yes Yes Yes Yes Yes Yes Yes	No No No No No No No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
• Certain Outpatient surgery procedures described under *Surgery - Outpatient.* • Certain Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*		Yes	No
	Out-of-Network		
	Primary Care Physician/Specialist		
	Office Visit In-Person	Yes	No
	$195 per visit		
	Telehealth Visit		
	$195 per visit	Yes	No
	Visit in the Home		
	$75 per visit	Yes	No
	Convenience Care/Retail	Yes	No
	$30 per visit		
	Allergy Injections		
	$100 per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Biofeedback $135 per visit	Yes	No
	E-Visit/Telephone Visit $195 per visit	Yes	No
	Anticoagulant Management $45 per visit	Yes	No
22. Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
Note: returning home with Durable Medical Equipment, such as a fetal monitor, following an office visit or inpatient admission may result in an additional Co-payment. Co-	***Network*** *Routine Prenatal and Postnatal Care*	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	None per visit		
	Amniocentesis		
	$275 per test	Yes	No
	Chorionic Villus Sampling (CVS)		
	$325 per test	Yes	No
	Home Birth		
	$625 per delivery	Yes	No
	Inpatient Delivery		
	*$625 to $1,375 per Inpatient Stay, except that if a newborn stays in the Hospital longer than the mother, an additional Co-payment will apply for the newborn Inpatient Stay.	Yes	No
	All Other Services		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
	Out-of-Network		
	Routine Prenatal and Postnatal Care $100 per visit	Yes	No
	Amniocentesis $825 per test	Yes	No
	Chorionic Villus Sampling (CVS) $975 per test	Yes	No
	Home Birth $1,875 per delivery	Yes	No
	Inpatient Delivery $4,125 per Inpatient Stay, except that if a newborn stays in the Hospital longer than the mother, an additional Co-payment will apply for the newborn Inpatient Stay.	Yes	No

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	All Other Services Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
23. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will be the same as, and combined with, those stated under *Fertility Preservation for Iatrogenic Infertility*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider.*	***Network*** per visit	Yes	No
	Out-of-Network per visit	Yes	No

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
24. Preventive Care Services			
Physician office services	***Network*** None	No	No
	Out-of-Network $100 per visit	Yes	No
Lab, X-ray or other preventive tests	***Network*** None	No	No
	Out-of-Network *Major Diagnostic Imaging* $1,500 per visit	Yes	No
	All Other Services None per service	Yes	No
Breast pumps	***Network*** None	No	No
	Out-of-Network Benefits will be the same as stated under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* in this *Schedule of Benefits.*		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
25. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
Note: returning home with Durable Medical Equipment, such as a walker, following a reconstructive procedure may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		

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Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 60 visits of physical therapy. • 60 visits of occupational therapy and cognitive rehabilitation therapy combined. • 60 Manipulative Treatments. • 60 visits of speech therapy. Visits limits above for Manipulative Treatment, physical therapy, occupational therapy, and speech therapy do not apply for the treatment of Mental Illness or substance-related and addictive disorders. Note: returning home with Durable Medical Equipment, such as a walker, following rehabilitation therapy may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME),*	***Network*** *Manipulative Treatment* $15 per treatment	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Orthotics, Prosthetic Devices, and Supplies category in this *Schedule of Benefits*.			
	Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $10 per visit	Yes	No
	Occupational Therapy for All Other Conditions *$10 to $60 per visit	Yes	No
	Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $10 per visit	Yes	No
	Physical Therapy for All Other Conditions *$10 to $50 per visit	Yes	No
	Speech Therapy for the Treatment of Mental Illness and Substance-		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Related and Addictive Disorders $10 per visit	Yes	No
	Speech Therapy for All Other Conditions *$10 to $60 per visit	Yes	No
	Pulmonary Rehabilitation Therapy $40 per visit	Yes	No
	Cardiac Rehabilitation Therapy $30 per visit	Yes	No
	Post-cochlear Implant Aural Therapy *$10 to $65 per visit	Yes	No
	Cognitive Rehabilitation Therapy *$10 to $60 per visit	Yes	No
	Out-of-Network *Manipulative Treatment*	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	$45 per treatment *Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders* $30 per visit	Yes	No
	Occupational Therapy for All Other Conditions $180 per visit	Yes	No
	Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders $30 per visit	Yes	No
	Physical Therapy for All Other Conditions $150 per visit	Yes	No
	Speech Therapy for the Treatment of Mental Illness and Substance-		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Related and Addictive Disorders $30 per visit	Yes	No
	Speech Therapy for All Other Conditions $180 per visit	Yes	No
	Pulmonary Rehabilitation Therapy $120 per visit	Yes	No
	Cardiac Rehabilitation Therapy $90 per visit	Yes	No
	Post-cochlear Implant Aural Therapy $195 per visit	Yes	No
	Cognitive Rehabilitation Therapy $180 per visit	Yes	No
27 Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Prior Authorization Requirement			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network		
	Level 1 Procedure		
	*$20 to $1,200 per visit	Yes	No
	Level 2 Procedure	Yes	No
	*$30 to $2,500 per visit		
	Level 3 Procedure	Yes	No
	*$150 to $2,500 per visit		
	All Other Procedures	Yes	No
	*$75 to $500 per visit		
	Out-of-Network		
	Level 1 Procedure		
	**$3,600 per visit	Yes	No
	Level 2 Procedure		
	**$7,000 per visit	Yes	No
	Level 3 Procedure		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	****$7,000 per visit	Yes	No
	All Other Procedures		
	$1,500 per visit	Yes	No
28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to: • 120 days per year in a Skilled Nursing Facility. • Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit. Note: returning home with Durable Medical Equipment, such as a walker, following an admission may	***Network*** *Skilled Nursing Facility* $1,200 per Inpatient Stay *Inpatient Rehabilitation Facility* $1,200 per Inpatient Stay	Yes Yes	No No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	***Out-of-Network*** *Skilled Nursing Facility* $3,600 per Inpatient Stay *Inpatient Rehabilitation Facility* $3,600 per Inpatient Stay	Yes Yes	No No
29. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for all outpatient surgeries, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Note: returning home with Durable Medical Equipment, such as crutches, following an outpatient	***Network*** *Level 1 Procedure*		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
surgery may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	*\$20 to \$1,200 per visit	Yes	No
	Level 2 Procedure		
	*\$30 to \$2,500 per visit	Yes	No
	Level 3 Procedure		
	*\$150 to \$2,500 per visit	Yes	No
	All Other Procedures		
	*\$75 to \$500 per visit	Yes	No
	Out-of-Network		
	Level 1 Procedure		
	**\$3,600 per visit	Yes	No
	Level 2 Procedure		
	**\$7,000 per visit	Yes	No
	Level 3 Procedure		
	**\$7,000 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	All Other Procedures $1,500 per visit	Yes	No
30. Temporomandibular Joint (TMJ) Services and Orthognathic Surgery			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before TMJ or orthognathic surgery services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.			
Note: returning home with Durable Medical Equipment, such as an oral appliance, following orthognathic surgery may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits.*	***Network*** *Orthognathic Surgery* $2,400 per Inpatient Stay *All Other Services*	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	Inpatient $1,600 per Inpatient Stay *Outpatient Office Visit* *$10 to $65 per visit *Outpatient Hospital* *$75 to $500 per visit ***Out-of-Network*** *Orthognathic Surgery* $7,000 per Inpatient Stay *All Other Services* *Inpatient* $4,800 per Inpatient Stay *Outpatient Office Visit* $195 per visit *Outpatient Hospital* $1,500 per visit	Yes Yes Yes Yes Yes Yes Yes	No No No No No No No
31. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement			

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

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

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
For Out-of-Network Benefits, you must obtain prior authorization for all outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network		
	Dialysis - Home $45 per visit	Yes	No
	Dialysis - All Other Settings *$50 to $340 per visit	Yes	No
	Apherisis *$120 to $340 per visit	Yes	No
	Hyperbaric Oxygen Therapy *$100 to $725 per visit	Yes	No
	Chemotherapy *$160 to $500 per visit	Yes	No
	Radiation Oncology *$30 to $1,500 per visit	Yes	No
	Out-of-Network		

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

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

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Dialysis - Home $135 per visit	Yes	No
	Dialysis - All Other Settings $1,020 per visit	Yes	No
	Apherisis $1,020 per visit	Yes	No
	Hyperbaric Oxygen Therapy $2,175 per visit	Yes	No
	Chemotherapy $1,500 per visit	Yes	No
	Radiation Oncology **$4,500 per visit	Yes	No
32. Transplantation Services			

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
33. Urgent Care Center Services			
Note: returning home with Durable Medical Equipment, such as a crutches, following an urgent care visit may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* category in this *Schedule of Benefits*.	***Network*** $30 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
	Out-of-Network $90 per visit	Yes	No
34. Virtual Care Services			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by visiting benefits.surest.com or calling the telephone number on your ID card.	***Network*** None per visit	Yes	No
	Out-of-Network **$10 per visit	Yes	No
35. Vision Exams			

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

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

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Limited to 1 exam every year.	***Network***		
	None per visit	Yes	No
	Out-of-Network		
	$195 per visit	Yes	No

Additional Benefits Required By Nevada Law

36. Autism Spectrum Disorder	
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Benefits for *Applied Behavioral Analysis (ABA)* for Covered Persons under age 18 or, if enrolled in high school, until age 22. *Applied Behavioral Analysis (ABA)* is limited to 1,500 hours per year.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**			
Covered Health Care Service	**What Is the Co-payment You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does an Annual Deductible Apply?**
37. Dental - Anesthesia and Hospital Facility Charges for Enrolled Dependent Children			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
38. Telehealth Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.
***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.** ****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Covered Health Care Service category in this *Schedule of Benefits* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

Allowed Amounts

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

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

provider may not bill you, for amounts in excess of your Co-payment which is based on the Recognized Amount as defined in the *Certificate.*

- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate.*
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

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

Network Benefits

Allowed Amounts are based on the following:

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

Out-of-Network Benefits

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

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

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

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate*.
- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

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

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

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

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

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.*
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently

created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

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

Provider Network

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

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

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

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients.

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

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. For assistance visit benefits.surest.com or call the telephone number on your ID card.

Continuity of Care

If you are under the care of a Network provider and the Network provider caring for you is terminated from the Network by us, we can arrange (at your request and subject to the provider's agreement) for continuation of Covered Health Care Services rendered by the terminated provider for the time periods shown below. Co-payments, Co-insurance, any deductible, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us. 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.

The time periods for which treatment by a terminated Network provider will be covered under the Policy are:

- Pregnancy. The 90th day after either of the following:
  - The date of delivery.
  - The date of the end of the Pregnancy, if the Pregnancy does not end in delivery.
- Other than Pregnancy.
  - The 120th day after the date the provider's contract is terminated.

Continuity of care does not apply when:

- The provider's contract was terminated for failure to meet applicable quality standards or for fraud.
- The provider of health care was under contract with us and we terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and
- We did not enter into another contract with the provider of health.

Designated Providers

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

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

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

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

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

Benefits for Oral Chemotherapeutic Agents

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 your *Certificate of Coverage,* regardless of tier placement. For oral chemotherapeutic agents, the total amount of any applicable deductibles or Co-payments shall not exceed $100 for an individual prescription of up to a 30-day supply. Oral chemotherapeutic agents may not be subject to dollar limits that are less favorable for chemotherapy administered orally than the dollar limits applicable to chemotherapy administered by injection or intravenously, nor decrease the dollar limits applicable to chemotherapy adminstered orally or to chemotherapy which is administered by injecton or intravenously.

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

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

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

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

How Do Supply Limits Apply?

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

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

You may find out whether a Prescription Drug Product has a supply limit for dispensing by visiting benefits.surest.com or calling the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

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

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

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

Network Pharmacy Prior Authorization

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires prior authorization by visiting benefits.surest.com or calling the telephone number on your ID card.

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

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and Ancillary Charge. Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service, or it is an Experimental or Investigational or Unproven Service.

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

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. If this is the case, we will work with your prescribing practitioner on the clinical criteria for the step therapy protocol. For a Covered Person who has been diagnosed with stage 3 or 4 cancer, a provider may submit a medical rationale for determining that a particular step therapy is not appropriate for a particular patient based on the patient's medical condition and history.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by visiting benefits.surest.com or calling the telephone number on your ID card.

What Do You Pay?

You are responsible for paying the applicable Co-payment described in the Benefit Information table in addition to any Ancillary Charge. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment for Prescription Drug Products on the List of Zero Cost Share Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is Chemically Equivalent.

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

- Ancillary Charges.
- Any amount you pay for Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) that exceeds the Maximum Policy Benefit.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term and Description	Amounts
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT)] Maximum Policy Benefit	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	$5,000 per Covered Person.
Co-payment	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-payment*** Your Co-payment is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment by visiting benefits.surest.com or calling the telephone number on your ID card. Your Co-payment may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by visiting benefits.surest.com or calling the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments stated in the *Benefit Information* table for amounts. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment for Prescription Drug Products on the List of Zero Cost Share Medications.

Payment Term and Description	Amounts
Your Co-payment for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment based on your condition and/or actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by visiting benefits.surest.com or calling the telephone number on your ID card. **Variable Co-payment Program:** Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment may vary when you use a coupon. Contact benefits.surest.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please visit benefits.surest.com or call the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.	
Description and Supply Limits	**What Is the Co-payment You Pay?**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy or a Designated Pharmacy.	Your Co-payment is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please visit benefits.surest.com or call the telephone number on your ID card to find out tier placement. For a Tier 1 Specialty Prescription Drug Product: $170 per Prescription Order or Refill For a Tier 2 Specialty Prescription Drug Product: $200 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $230 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if youpay a Co-payment for each cycle supplied. You may receive up to a 12-month cycle of the same	Your Co-payment is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please visit benefis.surest.com or call the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.	
Description and Supply Limits	**What Is the Co-payment You Pay?**
contraceptive if you pay a Co-payment for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed or days the drug will be delivered. We may designate certain retail Network Pharmacies to be Preferred Retail Network Pharmacy. We may, from time to time, change the Preferred designation of a retail Network Pharmacy. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you. You may find out whether a retail Network Pharmacy is a Preferred Retail Network Pharmacy by visiting benefits.surest.com or calling the telephone number on your ID card.	
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment based on the day supply dispensed for any Prescription Orders or Refills sent to the	Your Co-payment is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please visit benefits.surest.com or call the telephone number on your ID card to find out tier status. For up to a 31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 per Prescription Order or Refill. For up to a 60-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $30 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.	
Description and Supply Limits	**What Is the Co-payment You Pay?**
mail order Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	For a Tier 2 Prescription Drug Product: $80 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $120 per Prescription Order or Refill. For up to a 90-day supply at a mail order Network Pharmacy you pay: For a Tier 1 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $100 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $150 per Prescription Order or Refill.

Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

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

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

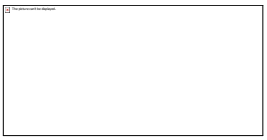
When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

Travel and Lodging Program

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

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

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



Jessica Paik, President