Certificate of Coverage 2025

Group Health Insurance Certificate
UnitedHealthcare Senior Supplement
Group: Connecticut Teachers' Retirement Board

retiree.uhc.com/TRB

Toll-free **1-866-794-3033**, TTY **711**
8 a.m.–8 p.m. local time, Monday–Friday

United Healthcare®

UnitedHealthcare Insurance Company

Group Health Insurance Certificate
UnitedHealthcare Senior Supplement

UnitedHealthcare Insurance Company (the “Company”) hereby delivers to the group policyholder a policy providing insurance for certain eligible covered persons. The certificate and schedule of benefits describe the benefits and provisions of the insurance provided by the policy.

You may receive the benefits specified in the certificate and schedule of benefits if you are eligible for insurance under the provisions of the policy.

The certificate is not a contract of insurance and only summarizes the primary provisions of the policy. The certificate supersedes and replaces any similar certificate that the company previously issued to you.

The certificate is valid only if it includes your schedule of benefits.

UnitedHealthcare Insurance Company

Jessica Paik, President

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Welcome to UnitedHealthcare

The company provides health care benefits to covered persons who have properly enrolled and meet the plan sponsor's eligibility requirements. This plan is designed to coordinate with Medicare and provide secondary coverage for services approved by Medicare.

To learn more about these requirements, see **Section Three: Covered Person Eligibility**.

What is this publication?

This publication is called a certificate of coverage (certificate). It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings.

To better understand these terms, please see **Section Five: Definitions**.

Whether you are the insured person for this coverage or enrolled as a dependent, your certificate and schedule of benefits are key to making the most of your coverage.

What else should I read to understand my benefits?

Along with reading this certificate and your schedule of benefits, be sure to review any supplemental benefit materials. Your schedule of benefits provides the details of your particular health plan, including any deductibles, copayments or coinsurance that you may have to pay when receiving a health care service. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to contact our customer service department as shown below:

- By calling 1-866-794-3033, TTY 711, 8 a.m.–8 p.m. local time, Monday–Friday
- By accessing our customer service website at retiree.uhc.com/TRB

Note: Your certificate and your schedule of benefits provide the terms and conditions of your benefits. These forms should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them. You may also correspond with the company at the following address:

retiree.uhc.com/TRB

UnitedHealthcare Insurance Company
P.O. Box 30770, Salt Lake City, UT 84130-0770

1-866-794-3033

Administrators

Certain provisions of the certificate are administered by one or more of the company's administrators.

For benefits verification and payment of claims:

UnitedHealthcare Insurance Company
P.O. Box 30995
Salt Lake City, UT 84130-0995
1-866-794-3033

All inquiries and notifications required by the terms and conditions of the policy or certificate are to be mailed or phoned to the company's administrator. Notification requirements to the company are fulfilled by contacting the company's administrator in this manner.

Section One: Your Medical Benefits

- Inpatient benefits
- Outpatient benefits
- Exclusions and limitations of benefits

This section explains your medical benefits, including what is and isn't covered by the company. All covered services must be medically necessary. If you have any questions as to whether a service or supply is a covered service, please consult this certificate or contact us at **1-866-794-3033**, TTY **711**. Our customer service department can assist you in determining your benefits. The company will evaluate submitted claims for medical necessity, and benefit payments may be adjusted or declined consistent with the evaluation findings. For any deductibles, copayments or coinsurance that may be associated with a benefit, you should refer to your schedule of benefits. Please consult your schedule of benefits and this **Section 1** for an explanation of your medical benefits, as well as the exclusions and limitations section of this certificate. You can also find some helpful definitions in **Section 5** at the back of this certificate.

If a specific service or supply is not included in this **Section One: Your Medical Benefits**, or in any supplemental benefit rider purchased by the covered person's plan sponsor, it is not a covered service and no benefits will be provided under the policy.

Your medical benefits

The benefits of the policy described in this certificate are based on the assumption that the covered person is enrolled in Medicare Part A and Part B. The company will pay the following benefits up to the covered expense, only to the extent that the Medicare eligible expense has not been paid by Medicare and subject to all other limitations and exclusions set forth in the policy and in the schedule of benefits. Covered persons must use Medicare participating providers, approved facilities and approved hospice agencies.

I. Inpatient benefits

Please refer to your schedule of benefits for further information including, but not limited to, any applicable copayments, coinsurance, deductibles, and limitations for all provisions listed in Section 1.

1. **Accidental ingestion or consumption of controlled drugs.** Emergency and inpatient coverage for treatment expenses arising from the accidental ingestion or consumption of a controlled drug is covered.
2. **Alcohol, drug or other substance abuse treatment and detoxification.** Inpatient treatment for alcohol, drug or other substance abuse is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.

3. **Blood and blood products.** Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
4. **Cancer clinical trials.** Clinical trials, subject to PHLIC review and approval for routine patient care costs based on the criteria below, are covered. If you join a clinical trial, the company will only pay the coinsurance or deductible as outlined for inpatient benefits in the schedule of benefits.

   An approved clinical trial is approved by one of the following:

   - One of the national institutes of health
   - A National Cancer Institute affiliated cooperative group
   - The federal Food and Drug Administration, as part of an investigational new drug or devise exemption
   - The United States Department of Defense
   - The United States Veterans' Administration

   Routine patient care costs means: (1) coverage for medically necessary health care services that are incurred as a result of the treatment being provided to the covered person for purposes of the cancer clinical trial that would otherwise be covered if such services were not rendered pursuant to a cancer clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the patient during the course of treatment in the cancer clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the covered person were not enrolled in a cancer clinical trial; and (2) coverage for routine patient care costs incurred for drugs provided to the covered person, as shown below, provided such drugs have been approved for sale by the federal Food and Drug Administration.

   Routine patient care costs shall not include: (1) The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; (2) the cost of a non-health-care service that a covered person may be required to receive as a result of the treatment being provided for the purposes of the cancer clinical trial; (3) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the cancer clinical trial; (4) costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the cancer clinical trial; (5) costs that would not be covered under the covered person's policy for noninvestigational treatments, including, but not limited to, items excluded from coverage under the covered person's contract with the insurer or health plan; and (6) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the cancer clinical trial, for the covered person or any family member or companion.

   Coverage for prescribed drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer shall not exclude coverage of any such drug on the

basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI).

A clinical trial with endpoints defined exclusively to test toxicity is not a covered expense.

5. **Foreign country travel benefit (medically necessary emergency services).** Medically necessary emergency hospital, physician and medical care services received in a foreign country. In order for services to be covered outside the United States by UnitedHealthcare, the service must be a covered benefit by Medicare Part A or Medicare Part B. Benefits will be:
   - Limited to charges covered if care had been provided in the United States;
   - Limited to treatment that began during the covered person's first six (6) months outside the United States. Proof of start of travel may be required;
   - Limited to covered persons whose primary residence is in the United States; and
   - Limited to those charges for which the covered person is required to pay.

   Note: Any charges for services incurred while in a foreign country are not covered unless specified in the schedule of benefits.

6. **Hospice services.** Hospice services are covered for covered persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six (6) months or less, if the sickness follows its natural course. Hospice services are provided as determined by the plan of care developed by the covered person's interdisciplinary team, which includes, but is not limited to, the covered person, the physician, a registered nurse and a social worker.

   Hospice services are provided in an appropriately licensed Medicare-approved hospice facility or program when the covered person's interdisciplinary team has determined that the covered person's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver, or when it is necessary to relieve the family members or other persons caring for the covered person ("respite care"). Respite care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

   Hospice services include: skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the covered person to maintain activities of daily living and basic functional skills.

7. **Hospital/acute care services.** Inpatient hospital services authorized by the company are covered, including but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the hospital-based pathologist, radiologist, or anesthesiologist, emergency room physician, emergency room and other miscellaneous hospital charges for care and treatment.
8. **Mastectomy, breast reconstruction after mastectomy and complications from mastectomy.** Medically necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the covered person incident to the mastectomy. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.
9. **Mental health care.** Inpatient psychiatric services in a Medicare-certified facility are covered.

   Services must be for “active treatment,” which is defined by the following criteria:

   - Services are provided under an individualized treatment or diagnostic plan;
   - Services are reasonably expected to improve the covered person’s condition or for the purpose of diagnosis; and
   - Services must be supervised and evaluated by a physician.
10. **Organ transplant and transplant services.** Non-experimental and non-investigational organ transplants and transplant services are covered when the recipient is a covered person and the transplant is performed at a Medicare participating facility. Food and housing is not covered.

    Autologous and allogeneic bone marrow and stem cell transplants are covered. The testing of blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the covered person is the intended recipient.
11. **Physician services.** Services from physicians, including specialists and other licensed health professionals are covered while the covered person is hospitalized as an inpatient.
12. **Reconstructive surgery.** Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or sickness is covered. Coverage for medically necessary removal of breast implants which were implanted on or before July 1, 1994, without regard to the purpose of such implantation. The primary purpose of reconstructive surgery is to correct abnormal structures of the body to improve function.

13. **Rehabilitation services.** Rehabilitation services that must be provided in an inpatient rehabilitation facility are covered. Rehabilitation services are the individual or combined and coordinated use of medical, physical, occupational and speech-language pathology services for training and retraining individuals disabled by sickness or injury. A rehabilitation facility provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities.
14. **Skilled nursing services/subacute and transitional care.** Medically necessary inpatient skilled nursing services in a Medicare-certified skilled nursing facility are covered. Skilled nursing services are covered if the insured requires skilled nursing services or skilled rehabilitation services on a daily basis and these skilled services can be provided only on an inpatient basis in a skilled nursing facility. Inpatient stays solely to provide custodial care are not covered.

    Covered services include, but are not limited to the following: Semi-private room (private room if medically necessary); meals, including special diets; regular nursing services; physical therapy, occupational therapy, and speech-language pathology services; drugs (this includes substances that are naturally present in the body, such as blood clotting factors); blood; medical and surgical supplies; laboratory tests; X-rays and other radiology services; use of appliances such as wheelchairs; and physician services.

II. Outpatient benefits

Please refer to your schedule of benefits for further information including, but not limited to, any applicable copayments, coinsurance, deductibles, and limitations for all provisions listed in Section 1.

1. **Accidental ingestion or consumption of controlled drugs.** Outpatient coverage for treatment arising from the accidental ingestion or consumption of a controlled drug is covered.
2. **Alcohol, drug or other substance abuse detoxification.** Alcohol, drug or other substance abuse detoxification is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.

    Smoking cessation counseling sessions are covered for an enrollee with a disease aggravated by tobacco; performed by a health care professional within the scope of his or her licensure.
3. **Ambulance.** The use of an ambulance (land or air) is covered when the covered person, as a prudent layperson, reasonably believes that the medical or psychiatric condition requires services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the “911” emergency response system. Ambulance transportation is limited to the nearest available emergency facility having the expertise to stabilize the covered person’s emergency medical condition. Use of an ambulance for non-emergency services is limited to inter-facility transfers between two hospitals, between a hospital and a non-custodial skilled nursing

facility, or between a non-custodial skilled nursing facility and dialysis or radiation therapy are covered when medical necessity criteria for an ambulance is met.

4. **Autism spectrum disorder.** Medical services including physical therapy, speech therapy and occupational therapy for the treatment of autism spectrum disorders are covered when such services are medically necessary and are otherwise covered services under the policy. Autism spectrum disorder is defined as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
5. **Blood and blood products.** Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
6. **Contraceptive drugs.** Contraceptive drugs or devices that are approved by the United States Food and Drug Administration for use as a contraceptive and that are obtained under a prescription are covered.
7. **Dental treatment anesthesia.** See "Oral Surgery and Dental Services" and "Oral Surgery and Dental Services: Dental Treatment Anesthesia" provisions below.
8. **Diabetic management and treatment.** Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and be prescribed by a provider acting within the scope of his or her licensure.

   Services for laboratory and diagnostic tests for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes are covered. Such coverage will include medically necessary equipment, drugs and supplies prescribed by a prescribing provider in accordance with the covered person's treatment plan.

   Medicare may cover up to 10 hours of initial DSMT—1 hour of individual training and 9 hours of group training. You may also qualify for up to 2 hours of follow-up training each year if it takes place in a calendar year after the year you got your initial training.
9. **Diabetic self-management items.** Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the covered person, including but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; insulin pumps and all related necessary supplies; ketone urine testing strips; podiatry services and devices to prevent or treat diabetes related complications.
10. **Dialysis.** Acute and chronic dialysis services and supplies are covered.
11. **Drugs and prescription medication covered by Medicare**
    - **Outpatient prescription drugs.** The following outpatient prescription drugs are covered when approved by Medicare: Osteoporosis drugs; erythropoietin (epogen) or epoetin alfa; hemophilia clotting factors; immunosuppresive drugs; oral cancer drugs; and oral anti-nausea drugs.

- **Infusion therapy.** Infusion therapy means the therapeutic use of drugs or other substances, prepared or compounded, and administered by a provider and given to a covered person through a needle or catheter. Services must be provided in the covered person's home or an institution that is not a hospital or is not primarily engaged in providing skilled nursing or rehabilitation services. (For example, board and care, custodial care facility and assisted living facility.) Infusion therapy is only covered as part of a treatment plan prescribed by a physician.
- **Outpatient injectable medications.** Outpatient injectable medications include those drugs or preparations that are not usually self-administered, and which are given by the intramuscular or subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as a customary component of a physician's office visit and when not otherwise limited or excluded (e.g., insulin, certain immunizations, infertility drugs, birth control, or off-label use of covered injectable medications).

12. **Durable medical equipment (rental, purchase or repair).** Durable medical equipment is covered when it is designed to assist in the treatment of an injury or sickness of the covered person, and the equipment is for use in the home. Durable medical equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered durable medical equipment include wheelchairs, hospital beds and standard oxygen delivery systems.

    Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the covered person's physical condition.
13. **Eye exams.** Some preventive eye tests and screenings are covered. Coverage includes a yearly eye exam for diabetic retinopathy, and a glaucoma screening every twelve (12) months for people with diabetes or a family history of glaucoma, or for African Americans age 50 and older. Ocular photodynamic therapy with verteporfin, a treatment for patients with age-related macular degeneration, is also covered.
14. **Eyewear.** Eyewear and corrective lenses are covered following cataract surgery with an intraocular lens (IOL) and when the covered person is missing an intraocular lens without a replacement either after cataract surgery or naturally. If an IOL is placed, the covered person is entitled to one pair of frames and lenses after each cataract surgery. If the covered person does not have an IOL, then the covered person is covered for ongoing contacts and glasses through the prosthetic benefit.
15. **Foreign country travel benefit (medically necessary emergency services).** Medically necessary emergency hospital, physician and medical care services received in a foreign country are covered. Benefits will be: (1) limited to charges covered if care had been provided in the United States; (2) limited to treatment that began during the covered person's first six (6) months outside the United States. Proof of start of travel may be required; (3) limited to covered persons whose primary residence is in the United States; and (4) limited to those charges for which the covered person is required to pay.

Note: Any charges for services incurred while in a foreign country are not covered unless specified in the schedule of benefits.

16. **Hearing exams.** Diagnostic hearing exams are covered.
17. **Home health care.** Covered home health services include, but are not limited to: 1) part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; 2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; 3) physical, occupational or speech therapy; 4) medical supplies, drugs and medicines prescribed by a physician, an advanced practice registered nurse or a physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; 5) medical social services, provided to or for the benefit of a covered person diagnosed by a physician as terminally ill with a prognosis of six months or less to live. Medical social services are defined to mean services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to 1) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; 2) appropriate action and utilization of community resources to assist in resolving such problems; 3) participation in the development of the overall plan of treatment for such covered person.

    Part-time or intermittent means the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy, except in the case of a covered person diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit; four hours of home health aide service shall be considered as one home health care visit.

    A homebound covered person has restricted ability, due to an illness or Injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker), or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, You may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the state, or to attend religious services. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

18. **Laboratory and diagnostic services.** Medically necessary diagnostic and therapeutic laboratory services and other medically necessary diagnostic services are covered.
19. **Leukemia treatment.** Treatment of leukemia, including outpatient chemotherapy is covered.
20. **Lyme disease treatment.** Lyme disease treatment including intravenous antibiotic therapy, oral antibiotic therapy, or both, and will provide further treatment if recommended by a board certified licensed rheumatologist, infectious disease specialist or neurologist are covered.
21. **Medical supplies and materials.** Medical supplies and materials necessary to treat a Sickness or Injury are covered when used or furnished while the covered person is being treated in the provider's office or in the home by a licensed health care professional, or used in conjunction with durable medical equipment for proper functioning of the durable medical equipment.
22. **Medically necessary appliances.** Medically necessary appliances and supplies relating to ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors are covered.

    Hypodermic needles or syringes prescribed by a prescribing practitioner, for the purpose of administering medications for medical conditions, are covered under the policy.
23. **Mental health care.** Outpatient psychiatric services must meet the following criteria to be covered:
    - Services incident to a physician's service;
    - Services for the purpose of diagnostic study or would reasonably be expected to improve the covered person's condition;
    - The treatment must be designed to reduce or control the covered person's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning;
    - Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician;
    - Services must be supervised and evaluated by a physician to determine the extent to which treatment goals are being realized;
    - Partial hospitalization services when the covered person is discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment;
    - Partial hospitalization services for covered persons who, in the absence of partial hospitalization, would be at reasonable risk of requiring hospitalization.
24. **Oral surgery and dental services.** Emergency services for stabilization of an acute injury to sound natural teeth, the jawbone or surrounding structures are covered.

    Other covered oral surgery and dental services include:

- Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of temporomandibular joint ("TMJ") syndrome;
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol; and
- Tooth extraction prior to a major organ transplant or radiation therapy to the head or neck.

25. **Oral surgery and dental services: Dental treatment anesthesia.** Anesthesia and associated facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when the covered person's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting.
26. **Outpatient surgery.** Short stay, same day or other similar outpatient surgery services (of less than twenty-four (24) hours) are covered when provided as a substitute for Inpatient care at a hospital or licensed free-standing outpatient surgical center.
27. **Pain management treatment.** Medically necessary treatment plan diagnosed and ordered by a pain management specialist to include the use of necessary medications and procedures to manage the pain are covered.
28. **Periodic health screenings.** Periodic health screenings are covered and shall not exceed the limits shown below. This benefit includes the following health screenings:
    a. Diagnostic hearing screening. Hearing examination to evaluate hearing loss. Further diagnostic testing by an audiologist, including hearing and balance assessment services, when the covered person's physician orders the testing as part of a diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. These services are not covered when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for the appropriate type of hearing aid.
    b. Immunizations for adults are covered consistent with the most current recommendations of the Centers for Disease Control and Prevention (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices.
    c. Diagnostic laboratory services (age and gender appropriate) in conjunction with an office visit.
    d. Breast and pelvic cancer screening and diagnosis. Services for the screening and diagnosis of breast cancer, including a clinical breast exam and a pelvic examination with pap smear once every twenty-four (24) months. If the covered person is at high risk for cervical or vaginal cancer, or if the covered person is of childbearing age and has had an abnormal pap test, this test is covered once every twelve (12) months. Mammography for screening or diagnostic purposes is covered as follows:

- A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; or
- A mammogram for women age 40 and over every twelve (12) months; and
- One baseline mammogram between the ages of 35 and 39.

Covered services include additional ultrasound screening of the entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on:

- The Breast Imaging Reporting and Data system established by the American College of Radiology, or
- If a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse.

e. Colorectal cancer screening includes an examination to include but not limited to the following:
   - A fecal occult blood test performed once every twelve (12) months;
   - A colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.

f. Detection of osteoporosis using bone mass measurement used for the detection of low bone mass and for the determination of the covered person's risk of osteoporosis and fractures associated with osteoporosis. Osteoporosis detection services are covered services when provided to the following qualified covered persons:
   - Postmenopausal women who are not receiving estrogen replacement therapy;
   - Individuals with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures;
   - Individuals who are receiving long-term glucocorticoid therapy; or
   - Individuals who are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

g. Bone mass measurements if the following conditions are met:
   - The test must be ordered by a doctor or qualified practitioner who is treating you;
   - Every two (2) years or more frequently if medically necessary; and
   - One or more of the following conditions are met: women who are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on their medical

history and other findings; men and women on prednisone or steroid-type drugs or who are planning to begin such treatment; men and women diagnosed with primary hyperparathyroidism; men and women being treated with a drug for osteoporosis, to determine if the therapy is working.

h. Diagnostic laboratory services are limited to the following tests (as defined in Current Procedural Terminology (CPT) from the American Medical Association): complete blood count (CBC), urinalysis, thyroid stimulating hormone (TSH), prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT), and organ or disease oriented panels. Components of the above tests are also covered if ordered individually.

i. Standard X-rays. Standard X-rays are covered for the diagnosis of a Sickness or Injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms), mammograms, obstetrical ultrasounds, and bone mineral density studies (including ultrasounds and DEXA scans).

j. Prostate screening. Evaluations for the screening and diagnosis of prostate cancer are covered for

   - men who are symptomatic; or
   - men whose biological father or brother has been diagnosed with prostate cancer, or
   - men age 50 and older.

   This screening may include, but is not limited to, the following:

   - Prostate-specific antigen testing
   - Digital rectal examination

k. Glaucoma screening once every twelve (12) months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African Americans who are age 50 and older.

l. Flu shot once a year in the fall or winter.

m. Pneumococcal pneumonia shot (vaccine).

n. Hepatitis B shot (vaccine) if there is medium to high risk for Hepatitis B.

o. A foot exam is covered every six (6) months. Coverage is for individuals with diabetic peripheral neuropathy and loss of protective sensations, as long as there are no other visits to a foot care professional for another reason.

29. **Physician office visits.** Services for the detection and treatment of an injury or sickness during or associated with a physician's office visit are covered. Covered services may include:

- Antigens
- Breast and pelvic cancer screening including mammography screening
- Colorectal cancer screenings

- Detection of osteoporosis
- Diabetes self-monitoring training and supplies
- Immunizations
- Immunosuppressives
- Inhalation solutions
- Oral chemotherapy
- Pap smear
- Pelvic exam
- Prostate cancer screening
- Neuropsychological testing for a child diagnosed with cancer when ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in the child due to chemotherapy or radiation treatment. Any preauthorization requirement does not apply to this benefit.

30. **Podiatry services.** Services of a podiatrist for medically necessary treatment of injuries or diseases of the foot, such as hammer toe or bunion deformities and heel spurs are covered. A foot exam is covered every six (6) months for people with diabetic peripheral neuropathy and loss of protective sensations as long as there has been no other covered visit to a foot care professional for another reason between visits.
31. **Preventive care services.** Preventive care services are limited to periodic health screenings, as shown in this section, including: physician, lab, radiology or other tests; preventive measures or related services considered medically necessary and appropriate for age and gender to determine a covered person's health status.

    Benefits will be based on the actual charges made by the provider up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes (where applicable or based on usual and customary charges). This benefit will not include payment for any procedure covered by Medicare.
32. **Prosthetics and corrective appliances.** Prosthetics are covered. Bionic and microprocessors are covered only when approved by Medicare. Custom-made or custom-fitted corrective appliances are covered. Replacements, repairs and adjustments to corrective appliances and prosthetics are limited to normal wear and tear or because of a significant change in the covered person's physical condition.

    Cost for any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment of head and neck tumors or additional appliances essential for the support of such prosthesis are covered. A wig, when prescribed by a licensed oncologist for a patient who suffers from hair loss as result chemotherapy, is covered.
33. **Radiation therapy.** Services for radiation therapy are covered.

34. **Reconstructive surgery.** Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or sickness is covered. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function.
35. **Rehabilitation services and therapy.** Covered outpatient services include physical therapy, speech therapy and occupational therapy for the treatment of a sickness or injury, provided by a licensed health care professional or under the direct supervision of a licensed health care professional.
36. **Specialized footwear.** Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes, is covered for a covered person with diabetic foot disease or when an orthopedic shoe is permanently attached to an orthopedic brace.
37. **Specialized scanning and imaging procedures.** Specialized scanning and imaging procedures are covered for the diagnosis of a sickness or injury. Specialized procedures are defined to include those which, unless specifically classified as standard X-rays, are digitally-processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of specialized scanning and imaging procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EKG, EEG, EMG and nuclear scans, angiograms (includes heart catheterization), arthrograms, and myelograms.
38. **Urgent care services.** Benefits include covered services from an urgent care facility.

III. Exclusions and limitations of benefits

The following treatments, services or supplies are either limited or not covered, as follows:

1. Any expense or service that is not determined by the company to be a Medicare eligible expense is not covered, unless coverage for the expense or service is specifically provided by this certificate or rider to the policy.
2. Any treatment, service or supply determined by the company to not be medically necessary is not covered. Payment for these services will be the covered person's financial responsibility.
3. Any service or supply determined by Medicare to not be necessary for the treatment of an illness or Injury is not covered, unless mandated in Connecticut.
4. Services not specifically included in **Section One: Your Medical Benefits**, or any supplemental benefit rider purchased by the covered person's plan sponsor, are not covered. Payment for these services will be the covered person's financial responsibility.
5. Services rendered prior to the covered person's effective date of enrollment or after the effective date of disenrollment are not covered.
6. The company does not cover the services or costs associated with a service that is not a covered service under the covered person's policy including, but not limited, to cosmetic surgery, bariatric surgery, and experimental and investigational procedures. This means that

the company will not cover follow-up care or complications associated with or arising from a non-covered service when:

a. The services or expenses are incurred in preparation for a non-covered service;

b. The complications or services are associated with non-covered services provided by another health plan or insurance company even if the service was covered under the prior plan;

c. The complications or services are associated with non-covered services the covered person paid for out-of-pocket (e.g., Cosmetic surgery, bariatric surgery, experimental and investigational procedures).

7. **Active military duty.** Services incurred as a result of active military duty are not covered.
8. **Air conditioners, air purifiers and other environmental equipment.** Air conditioners, air purifiers and other environmental equipment are not covered.
9. **Ambulance.** Ambulance services are not covered if they are not medically necessary or if used as a convenience for the covered person or his or her family. Wheelchair transportation services (e.g., a specially designed van or taxi) and personal transportation costs such as gasoline costs for a private vehicle or taxi fare are also not covered.
10. **Bariatric surgical procedures.** Bariatric surgical procedures are not covered.
11. **Behavior modification and non-crisis mental health counseling and treatment.** Behavior modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.
12. **Blood and blood products.** The costs of:
    - Transportation and processing for autologous, donor-directed or donor-designated blood are not covered in excess of the cost of a unit of blood from a recognized blood bank organization.
    - A platelet derived wound-healing formula such as procuren or other similar blood products used in the repair of chronic, non-healing, cutaneous ulcers or wounds are not covered.
    - Blood charges incurred by covered persons for services/supplies in conjunction with donating blood for another individual are not covered.
    - Blood charges associated with non-covered procedures are not covered.
13. **Bone marrow and stem cell transplants.** Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are experimental or investigational unless required by an external, independent review panel. Unrelated donor computer searches for covered persons who require a bone marrow or stem cell transplant are limited to the donor maximum for the covered person's transplant benefit.
14. **Complementary and alternative medicine.** Complementary and alternative medicine are not covered.
15. **Cosmetic services and surgery.** Cosmetic services and cosmetic surgery are not covered.

Cosmetic services and cosmetic surgery are services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic services or cosmetic surgery are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a covered person's dissatisfaction with his/her appearance, as influenced by that covered person's underlying psychological makeup or psychiatric condition.

16. **Custodial care.** Custodial care is not covered except for those services provided by an appropriately licensed hospice agency or appropriately licensed hospice facility incident to a covered person's terminal illness as described in the explanation of hospice services in the medical benefits section of this certificate.
17. **Dental care, dental services, dental appliances and orthodontics.** Except as otherwise provided under the outpatient benefit captioned "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental care refers to all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces, and orthodontic procedures. Dental splints, dental prosthesis or any dental treatment for the teeth, gums or jaw, or dental treatment related to temporomandibular joint syndrome (TMJ), are not covered unless provided by a supplemental benefit rider.
18. **Diagnostic admissions.** Services in connection with a hospital stay primarily for diagnostic tests which could have been performed on an outpatient basis are not covered.
19. **Disabilities connected to military services.** Treatment in a government facility for a sickness or injury connected to military service that the covered person is legally entitled to receive through a federal governmental agency, and to which the covered person has reasonable access, is not covered.
20. **Drugs and prescription medication (outpatient).** Outpatient drugs and prescription medications are not covered unless provided by a supplemental benefit rider. Refer to the drugs and prescription medication covered by medicare provision in the outpatient benefits section for benefit coverage. Pen devices for the delivery of medication are not covered.
21. **Durable medical equipment.** Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: non-medically necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the covered person; accessories for portability or travel; a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment; home and/or vehicle modifications to accommodate the covered person's physical condition.
22. **Educational services for developmental delays and learning disabilities.** Educational services to treat developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current

academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading, psychological and visual integration training.

23. **Elective enhancements.** Elective or voluntary enhancement services, procedures, treatments, supplies and medications, including but not limited to, services related to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance are not covered.
24. **Exercise equipment and services.** Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs, gyms, home exercise equipment or swimming pools, even if ordered by a health care professional.
25. **Experimental and/or investigational procedures, items and treatments.** Experimental and/or investigational procedures, items and treatments are not covered unless otherwise required by federal or state law. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is experimental or investigational, and therefore not a covered benefit, are determined by a company medical director, or his or her designee. Procedures, studies, tests, drugs or equipment will be considered experimental and/or investigational if any of the following criteria/guidelines is met:
    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
    - It has not been proven to have shown a demonstrable benefit for diagnosing or treating a particular illness or disease for which its use has been proposed in prevailing peer-reviewed literature.
    - It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
    - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.

- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not experimental or investigational itself pursuant to the above criteria, but would not be medically necessary except for its use in conjunction with a drug, device or treatment that is experimental or investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an experimental therapy).

The sources of information to be relied upon by the company in determining whether a particular treatment is experimental or Investigational, and therefore not a covered benefit under this plan include, but are not limited to, the following:

- The covered person's medical records;
- The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
- Any informed consent document the covered person, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- The published authoritative medical and scientific literature regarding the drug, device, treatment, or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations, e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman;
- Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Health Care Policy and Research ("AHCPR").

A covered person with a life threatening or seriously debilitating condition may be entitled to an expedited external, independent review of the company's coverage determination regarding experimental or investigational therapies.

26. **Eyewear and corrective refractive procedures.** Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered unless provided by an attached supplemental benefit rider. Surgical and laser procedures to correct or improve refractive error are not covered unless provided by an attached supplemental benefit rider. This exclusion does not apply following cataract surgery with an intraocular lens (IOL) and when the covered person is missing an intraocular lens without a replacement either after cataract surgery or naturally. If an IOL is placed, the covered person is entitled to one pair of frames and lenses after each cataract surgery. If the covered person does not have an IOL, then the covered person is covered for ongoing contacts and glasses through the prosthetic benefit.
27. **Family planning.** Family planning is not covered. Family planning is defined as services and supplies related to a surgical or medical voluntary termination of pregnancy. This exclusion

does not apply to therapeutic abortions where the mother's life is in danger or the fetus is not viable.

28. **Foot care.** Routine foot care, including, but not limited to, removal or reduction of corns and calluses, and clipping of toenails, is not covered.
29. **Foot orthotics/footwear.** Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes, is not covered. However, specialized footwear may be covered for covered persons with diabetic foot disease or when an orthopedic shoe is permanently attached to an orthopedic brace. (Refer to the "Prosthetics and Corrective Appliances" benefit in **Section One: Your Medical Benefits**.)
30. **Foreign country travel.** Any charges for services incurred while in a foreign country are not covered unless specified in the schedule of benefits.
31. **Genetic testing and counseling.** Genetic testing and counseling are excluded for all of the following:
    - Non-covered person.
    - Solely to determine the gender of a fetus.
    - Non-medical reasons (e.g., court-ordered tests, work-related tests, paternity tests).
    - Screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions during childhood.
    - Covered persons who have no clinical evidence or family history of a genetic abnormality.
    - Covered persons who do not meet the company's medical necessity criteria for genetic testing and counseling.
32. **Government services and treatment.** Any medical services that are paid by a local, state or federal governmental agency are not covered.
33. **Hearing aids and hearing devices.** Hearing aids and non-implantable hearing devices are not covered unless provided by a supplemental benefit rider. Hearing aid supplies are not covered. This exclusion for hearing aids and hearing devices does not apply to the first one thousand dollars for every 24-month period for a covered person twelve years of age or younger.
34. **Hearing examinations.** Audiology services performed only to determine the need for, or the appropriate type of, hearing aid are not covered unless provided by a supplemental benefit rider.
35. **Immunizations.** Travel and/or required work-related immunizations are not covered.
36. **Implants.** The following implants and services are not covered:
    - Removal and/or replacement of breast implants for non-medical reasons.
    - Replacement of breast prosthesis and the prosthesis itself following cosmetic breast augmentation mammoplasty, except as shown under mastectomy, breast reconstruction after mastectomy and complications from mastectomy.

37. **Infertility services.** Infertility services are not covered except as shown in the outpatient services section of this certificate.
38. **Institutional services and supplies.** Except for skilled nursing services provided in a skilled nursing facility, any services or supplies furnished by a facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered.
39. **Maternity services and education.** Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.
40. **Neuromuscular skeletal disorder services.** Services are limited to neuromuscular skeletal disorder services as described in the outpatient benefits section of this certificate and as provided by a supplemental benefit rider, if any.
41. **Nurse midwife services.** Elective home deliveries are not covered.
42. **Nursing, private duty.** Private duty nursing is not covered.
43. **Nutritional supplements or formulas.** Formulas, food, vitamins, herbs and dietary supplements are not covered.
44. **Off-Label drug use.** Off-label drug use means that the provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different from the use for which the FDA approved the drug. The Company excludes coverage for off-label drug use, including off-label self-injectable drugs, except as described in this certificate. If a drug is prescribed for off-label use, the drug and its administration will be covered only when it satisfies the following criteria:
    - The drug is approved by the FDA;
    - The drug is prescribed by a provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is medically necessary to treat the condition;
    - The covered person has failed, is intolerant of, or has contraindications to standard therapies;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Hospital Formulary Service Drug Information; The United States Pharmacopoeia Dispensing Information, Volume 1; or in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective.
45. **Organ donor evaluation and services.** Medical and hospital services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a covered person. Covered services for living donors are limited to transplant-related clinical services once a donor is identified. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children.

46. **Physical or psychological examinations.** Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other non-preventive health reasons are not covered.
47. **Private rooms and comfort items.** Personal or comfort items, and non-medically necessary private rooms during inpatient hospitalization, are not covered.
48. **Reconstructive surgery.** Reconstructive surgeries are not covered when there is another more appropriate surgical procedure that has been offered to the covered person, and the surgery does not restore body function.
49. **Recreational, lifestyle, educational or hypnotic therapy.** Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing, are not covered except for diabetic self-management training.
50. **Rehabilitation services and therapy.** Except as otherwise provided under the outpatient benefit captioned “Autism Spectrum Disorders”, rehabilitation services and therapy are either limited or not covered, as follows:
    - Speech, occupational or physical therapy are not covered when medical documentation does not support the medical necessity because of the covered person’s inability to progress toward the treatment plan goals or when a covered person has already met the treatment goals.
    - Speech therapy is limited to medically necessary therapy to treat speech disorders caused by a defined sickness, injury or surgery (for example, cleft palate repair). Speech therapy for stuttering, lisping or delayed speech is not covered.
    - Cognitive rehabilitation therapy is limited to initial neuropsychological testing by a treating physician or licensed provider and the medically necessary treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult. This benefit is subject to the maximum benefit for outpatient rehabilitation and applicable coinsurance and deductibles apply.
    - Exercise programs are only covered when they require the direct supervision of a licensed physical therapist and are part of a physician’s treatment plan.
    - Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and part of a physician’s treatment plan.
    - Massage therapy is not covered.
    - Activities that are motivational in nature or that are primarily recreational, social or for general fitness, are not covered.
    - Cognitive behavioral therapy is not covered.
    - Developmental and neuroeducational testing beyond initial diagnosis is not covered.
    - Developmental and neuroeducational treatment is not covered.
    - Hypnotherapy is not covered.

- Psychological testing is not covered.
- Vocational rehabilitation is not covered.

Rehabilitation services and therapies for the following conditions are not covered:

- Learning disability.
- Mental retardation and related conditions.

51. **Respite care.** Respite care is not covered, unless part of an authorized hospice plan and is necessary to relieve the primary caregiver in a covered person's residence. Respite care is covered only on an occasional basis, not to exceed five (5) consecutive days at a time.
52. **Reversal of sterilization procedures.** Reversal of sterilization procedures; sex change operations; conception by artificial means, which includes, but is not limited to, insemination procedures, in-vitro fertilization, zygote intrafallopian transfers and gamete intrafallopian transfers; and non-prescription contraceptive supplies and devices are not covered.
53. **Self-Injectable medications.** Self-injectable medications are defined as those drugs that are either generally self-administered by intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the subcutaneous route. Self-injectable medications are not covered except for the following:
    - Blood clotting factors.
    - Drugs used in immunosuppressive therapy.
    - Erythropoietin for dialysis patients.
54. **Services provided at no charge to the covered person.** Services and supplies that are provided free of charge if the covered person did not have coverage under this policy or for which the covered person will not be held financially responsible are not covered, unless the company has agreed to payment arrangements prior to the provision of the services or supplies to the covered person.
55. **Services while incarcerated or confined.** Services required for injuries or sicknesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered.
56. **Sex transformations.** Procedures, services, medications and supplies related to sex transformations are not covered.
57. **Sexual dysfunction or inadequacy medications.** Sexual dysfunction or inadequacy medications/drugs, procedures, services and supplies, including penile implants/prosthesis except testosterone injections for the documented low testosterone levels are not covered.
58. **Skin reduction surgery.** Surgical removal of excessive skin following massive weight loss associated with bariatric surgery or other weight loss programs is not covered.
59. **Surrogacy.** Infertility and maternity services for non-covered Persons are not covered.
60. **Transplant services.** Transplant services are not covered when the transplant is not

performed at a Medicare-certified transplant center. Non-human organs and artificial hearts are not covered.

61. **Transportation.** Transportation is not a covered benefit except as covered under the ambulance and organ transplant services benefits in this certificate.
62. **Veterans' Administration services.** Veterans' Administration (VA) services are not covered.
63. **Vision training.** Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
64. **Weight alteration programs.** Weight loss or weight gain programs are not covered.
65. **Workers' compensation.** Services payable under workers' compensation are not covered.
66. **War.** Services incurred as a result of declared or undeclared war are not covered.

Section Two: Payment Responsibility

- Claims policies and procedures
- Coordination of benefits

This section explains claims payment procedures and related claims matters. It also explains how the company will coordinate Your benefits with another plan.

I. Claims policies and procedures

The benefits of the policy are based on the assumption that the covered person is enrolled in Medicare Part A and Part B. The company may pay the benefits directly to you, to the physician, or to the hospital.

You should present your UnitedHealthcare identification card along with your Social Security Medicare identification on your first visit to the physician or hospital. Most providers bill both Medicare and the company for you. However, You may request that the provider contact the company for billing authorization and procedure.

Payment of benefits. The company will pay a benefit under the policy for the covered expense that a covered person incurs due to sickness or injury when the covered expense exceeds the plan year deductible and any other deductible that may apply. Benefits will be paid as set forth in the schedule of benefits. Benefits will not exceed any maximums or limits set forth in the policy. Benefits are subject to the exclusions and limitations specified in the policy. The definitions and all other terms and conditions of the policy that may limit or exclude benefits also apply in determining the payment of the benefits.

Non-duplication of benefits. Benefits provided under the policy will not duplicate any benefits paid by Medicare. The combined benefits provided under the policy and Medicare or other coverage will never exceed one hundred percent (100%) of the charges incurred for medical services and supplies. Additionally, if a service is covered under more than one provision of the policy, benefits will be provided under the provision that provides the greatest benefit, but not under both provisions.

Medicare assignment. If a provider of services accepts Medicare assignment, the company's payment will be limited to the difference between the amount paid by Medicare and the approved amount under Medicare, subject to any benefit limitations, deductibles, copayments and coinsurance set forth in the schedule of benefits.

Limitation of liability. The company shall not be obligated to pay any benefits under the policy for any claims if the proof of loss for such claim was not submitted within the period provided, unless it is shown that: (1) it was not reasonably possible to have submitted the proof of loss within such period; and (2) the proof of loss was submitted as soon as it was reasonably possible.

In no event will the company be obligated to pay benefits for any claim if the proof of loss for such claim is not submitted to the company within one (1) year after the date of loss, except in the case of legal incapacity of the covered person.

Claims processing. The company reviews and evaluates all service benefit payment submissions for medical necessity and the possibility of billing irregularities. The review relies on and complies with the American Medical Association guidelines and the Current Procedural Terminology system coding standards. The company may adjust or decline benefit payments consistent with the evaluation findings.

Notice of claim. A written notice of claim must be furnished to the company within twenty (20) days after a covered loss occurs or begins, or as soon thereafter as reasonably possible at

UnitedHealthcare Insurance Company
P.O. Box 30995
Salt Lake City, UT 84130-0995

The company, upon receipt of notice of claim, will furnish to the insured person such forms as are usually furnished for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the insured person shall be deemed to have complied with the requirements of the policy as to the proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which a claim is made.

Proof of loss. Written proof of loss must be furnished to the company at its office within ninety (90) days after the date of the loss. The company will not reduce or deny a claim for failure to furnish such proof within the time required, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, the company will not accept proof more than one (1) year from the time proof is otherwise required.

Time of payment of claims. Benefits for incurred medical expenses that are covered under the policy will be paid within forty-five (45) days of receipt of a proper claim by the company. If a claim does not contain all of the information necessary to pay or deny the claim, the company will request the required additional information within forty-five (45) days of receipt of the claim by the company. If the requested information is not provided within forty-five (45) days of the date it is requested, the company will deny the claim and provide the reasons for denial in writing.

Payment of benefits to insured person. All benefits, unless assigned under the policy, are payable to the insured person whose injury or sickness, or whose covered dependent's injury or sickness, is the basis of a claim.

Death of incapacity of insured person. In the event of the insured person's death or incapacity and in the absence of written evidence to the company of the qualification of a guardian for the insured person's estate, the company may, in its sole discretion, make any and all payments of benefits under the policy to the individual or institution that, in the opinion of the company, is or was providing the insured person's care and support.

Assignments. Benefits for covered expenses may be assigned by the covered person to the person or provider rendering the services. No such assignment will bind the company prior to the payment of the benefits assigned. The company will not be responsible for determining an assignment's validity. Payment of assigned benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered person and the assignee, is received prior to payment.

Legal actions. Any person may not bring legal action for benefits against the company:

1. Until at least sixty (60) days after proof of loss is sent to the company as required; or
2. More than three (3) years after the time for submitting proof has ended.

Physical examinations. The company, at its expense, may:

1. Have a covered person examined, as often as reasonably necessary, while any claim is pending; and
2. In the case of death of a covered person, have an autopsy made, where allowed by law, if a claim for benefits is made.

Direct payment for ambulance service. Benefits for covered expenses incurred by the covered person may be paid directly to the ambulance provider rendering such service, provided the ambulance provider has not received payment for such service from any other source.

To the extent of the payment, the company will have no more liability under the group policy.

II. Coordination of benefits

The company may coordinate benefits with benefits available under other similar health insurance policies. Coordination of benefits between policies may result in a reduction in the amount of benefits ordinarily payable, so that the covered person never receives a total, from all plans, of more than 100% of allowable expense incurred. All benefits provided under the policy are subject to this coordination provision.

What is a plan?

A "plan", as used in this coordination of benefits provision, means any of the following policies that provide benefits or services for medical or surgical treatment:

1. Group, blanket or franchise insurance coverage;
2. Prepaid coverage under service plan contracts, or under group or individual practice;
3. Any coverage under labor-management trusteed plans, union welfare plans, plan sponsor organization plans, or employee benefit organizations plans;
4. Any coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type plans;
5. Medicare or other governmental benefits, not including a state plan under Medicaid, and not including a plan when, by law, its benefits are in excess to those of any private insurance plan or other non-governmental plan; or
6. Any coverage under group-type contracts that is not available to the public and can only be obtained and maintained because of membership in or association with a particular organization or group.

Each plan, or other arrangement for coverage described above, is a separate plan. If a plan has two parts and the coordination of benefits provisions only applies to one part, each part is a separate plan. However, 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 coordination of benefits between those separate contracts.

What is an allowable expense?

Allowable expense means the usual, customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the covered person's stay in a private hospital room is considered medically necessary under at least one of the plans involved.

Order of benefit determination rules

The following rules determine the order of benefit payment:

1. A plan without a coordination of benefits provision pays before one with such a provision;
2. A plan which covers a person other than as a dependent pays before a plan which covers a person as a dependent;
3. When rules 1 through 2 do not establish the order of benefit determination, the plan covering the person for a longer period pays first; however:
   a. The plan covering the person as a laid-off or retired employee, or as a dependent of a laid-off or retired employee, will pay after any other plan covering that person as a full-time employee, or dependent of a full-time employee; and
   b. If the other plan does not have an order of benefit determination rule regarding laid-off or retired employees, then the provisions of rule 3.a. will not apply.

Effect on benefits

Benefits will be reduced when the policy is secondary to one or more other plans. Benefits will be reduced when the sum of:

1. The benefits payable for the allowable expense under this plan without this provision; and
2. The benefits payable for the allowable expense under the other plans, without this provision, whether or not a claim is made, exceed the allowable expense in a plan year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other plans does not total more than 100% of the allowable expense.

Right to receive and release information. For determining the applicability and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, the company may release or obtain from any insurance company or other organization or

person any information, with respect to any covered person, which the plan deems to be necessary for such purposes. Any covered person claiming benefits must furnish information necessary to implement this provision.

Reimbursement of payment. Payments made by any organization may be reimbursed by the company subject to policy limitations. Such reimbursements will fully discharge the company's liability under the policy.

Right of recovery. Whenever payments for covered expenses exceed the maximum payment necessary to satisfy the coordination of benefits provisions, the company may recover such excess payments. The term "payments for covered expenses" includes the reasonable cash value of any benefits provided in the form of services.

Third party liability and non-duplication of benefits to the extent permitted by law

1. **Third party liability.** Expenses incurred due to liable third parties are not covered.

   Health care expenses incurred by a covered person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act, or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this certificate. However, in all cases, the company will pay for the arrangement or provision of health care services for a covered person that would have been covered services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of this certificate captioned "the company's right to the repayment of a debt as a charge against recoveries from third parties liable for a covered person's health care expenses."

   The company's right to the repayment of a debt as a charge against recoveries from third parties liable for a covered person's health care expenses. Expenses incurred by a covered person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act, or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this certificate. However, in all cases, the company will pay for the arrangement or provision of health care services for a covered person that would have been covered services except that they were required due to a liable third party, in exchange for the following agreement:

   If a covered person is injured by a liable third party, the covered person agrees to give the company, or its representative, agent or delegate, a security interest in any money the covered person actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

   If the covered person does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the covered person will have no obligation to repay the covered person's debt to the company, which debt shall

include the cost of arranging or providing otherwise covered health care services to the covered person for the care and treatment that was necessary because of a liable third party.

The security interest the covered person grants to the company, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the covered person's health care services for injuries caused by a liable third party.

2. **Non-duplication of benefits**

   a. **Workers' compensation.** The company shall not furnish benefits under the policy to any covered person which duplicate benefits the covered person is entitled to under any workers' compensation law.

      In the event of a dispute regarding the covered person's receipt of benefits under workers' compensation laws, the company will provide the benefits described in the policy until resolution of the dispute.

      In the event the company provides benefits which duplicate the benefits the covered person is entitled to under workers' compensation law, the covered person agrees to reimburse the company for all such benefits provided by the company immediately upon obtaining any monetary recovery. The covered person shall hold any sum collected as the result of a workers' compensation action in trust for the company. Such sum shall equal the lesser of the amount of the recovery obtained by the covered person or the benefits furnished to the covered person by the company on account of each incident.

      The covered person agrees to cooperate in protecting the interests of the company under this provision. The covered person must execute and deliver to the company any and all liens, assignments or other documents necessary to fully protect the right of the company, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of the covered person.

   b. **TRICARE benefits.** The company shall not furnish benefits under the policy which duplicate the benefits to which the covered person is entitled under TRICARE. If payment is made by the company in duplication of the benefits available under TRICARE, the company may seek reimbursement up to the amount of benefits which duplicate such benefits under TRICARE.

   c. **Automobile, accident or liability coverage.** The company shall not furnish benefits which duplicate benefits the covered person is entitled to under any automobile, accident or liability coverage. The covered person is responsible for taking whatever action necessary to obtain the available benefits of such coverage, and will notify the company of receipt of such available benefits. If payment is provided by the company in duplication of the benefits under other automobile, accident or liability coverage, the company may seek reimbursement for the duplicate benefits. Should the cost of covered services exceed the benefits under any other liability coverage pursuant to this section, the policy benefits will be provided over and above such liability coverage.

d. In any case in which a husband and wife are employed by the same plan sponsor and by reason of their employment, are both eligible for coverage under the terms, such husband and wife shall not be required as a condition of their employment to pay any premium which does not result in greater coverage than would be provided if only one of them were eligible to participate in the group plan.

Section Three: Covered Person Eligibility

- Who is a covered person?
- Termination of benefits

I. Who is a covered person?

There are two kinds of covered persons: the insured person who enrolls under the policy through his or her plan sponsor, and the insured person's eligible dependents.

The coverage provided under the policy is made available to you because of your retirement from your plan sponsor. In order for you to participate in the plan sponsor's retiree welfare benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the plan sponsor's retiree welfare benefit plan are determined by the plan sponsor, or state and/or federal law. Eligibility requirements are described in general terms below. For more specific eligibility information, you should contact the human resources or benefits department of your plan sponsor.

Eligibility requirements

The insured person must be someone: (1) who has met all the eligibility requirements established by the plan sponsor for participation in the plan sponsor's retiree welfare benefit plan (including, but not limited to, having attained retirement eligibility under the plan sponsor's retiree welfare benefit plan); (2) who is age 65 or older; and (3) who is eligible for, and enrolled in, Medicare Part A and Part B. Eligible dependents of the insured person may be enrolled under the policy if such dependent is: (1) eligible for coverage under the plan sponsor's retiree welfare benefit plan; and (2) eligible for, and enrolled in, Medicare Part A and Part B.

Notification of eligibility change. Any covered person who no longer satisfies the eligibility requirements is not covered by the policy and has no right to any of the benefits described in the certificate. The company must be notified within thirty-one (31) days of any condition that may affect eligibility.

Effective date. An insured person or his or her dependent(s) may be enrolled for coverage under the policy in one of the four ways described below. Subject to payment of the applicable premium and the company's receipt of the appropriate enrollment forms, and in accordance with the provision below, personal or dependent insurance becomes effective as indicated in this section.

1. **Open enrollment.** If a retiree or a dependent enrolls during an open enrollment period, coverage will become effective on the first day of the insurance month following the end of the open enrollment period.
2. **Within 90 days of an eligibility date.** If a retiree or eligible dependent enrolls within ninety (90) days after first becoming eligible for coverage under the policy, personal insurance or dependent insurance will become effective on the first day of the insurance month following the date of enrollment.

3. **Late enrollment.** In the event a retiree or eligible dependent who is eligible for coverage under the policy declines enrollment for such coverage within ninety (90) days of becoming eligible, and subsequently requests enrollment, such retiree or dependent will not be eligible for coverage under the policy unless the retiree or dependent is eligible for special enrollment as described below.
4. **Special enrollment.** A special enrollment period of 90 days is provided for retirees or eligible dependents eligible to enroll for coverage under the policy when certain life events occur as determined by the plan sponsor.

   The effective date of coverage for the retiree or eligible dependent enrolled during this special enrollment period will be the first day of the insurance month following the date on which the retiree or dependent enrolled. Please contact the plan sponsor for special enrollment period events.

II. Termination of benefits

Individual terminations. A covered person's coverage will terminate on the earliest of the following:

1. The date the policy terminates;
2. The last day of the insurance month in which the covered person requests termination;
3. The last day of the last insurance month for which premium payment is made on behalf of the covered person;
4. The date the covered person ceases to be eligible for coverage under the policy; or
5. With respect to any particular insurance benefit, the date that benefit terminates.

Fraud or deception. Subject to the time limit on certain defenses provision of the policy, the company may terminate or rescind the policy or a covered person's coverage thereunder, if the following are true:

1. Such covered person knowingly provides the company with fraudulent information upon which the company relies; and
2. Such information materially affects the covered person's eligibility for enrollment or benefits under the policy. In such instance, the company shall send a written notice of termination or rescission to the insured person. It shall also refund any unearned premium which applies after the date of termination or rescission.

Fraudulent use of identification card. A covered person's eligibility for coverage under the policy shall immediately terminate if such covered person permits the use of his or her insurance identification card by any other person. In such instance, the company shall mail a written notice of termination to the covered person. It shall also refund any unearned premium which applies after the date of termination.

Please note: No coverage shall be in force and no benefit shall be payable for charges which are incurred after the date a covered person's coverage terminates for any reason under this certificate, except as provided by any applicable continuation coverage which the covered person elects and for which premium is submitted in a timely manner.

Coverage options following termination of individual coverage. A covered person may be entitled to the following continuation coverage options following termination of coverage:

- **Continuing coverage under state law.** In addition to the coverage options stated in the certificate, Connecticut law may require additional options. At the time of termination, the company will notify You of all available options.

Certificate of creditable coverage. According to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a certificate of creditable coverage will be provided to the insured person by the company when the insured person or a dependent ceases to be eligible for benefits under the group policyholder's health benefit plan. A certificate of creditable coverage may be used to reduce or eliminate a pre-existing condition exclusion period imposed by a subsequent health plan. Creditable coverage information for dependents will be included on the insured person's certificate, unless the dependent's address of record or coverage information is substantially different from the insured person's. Please contact the company's customer service department if you need a duplicate certificate of creditable coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your certificate of creditable coverage.

Section Four: Decisions Regarding Benefits

- Appealing a decision relating to benefits
- The appeals process

I. Appealing a decision relating to benefits

A covered person and the company may not always agree that a claim or request for services has been reviewed properly. When this happens, the covered person is encouraged to call the company's customer service department. The company's customer service department coordinator will assist the covered person and attempt to find a solution to the covered person's problem or grievance.

If the covered person feels that his/her problem or grievance requires additional action, the covered person may file a formal appeal. The company's appeals procedures are designed to deliver a timely response and resolution to a covered person's problem or grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem or grievance.

The covered person may submit written comments, documents, records, and any other information relating to the appeal, regardless of whether this information was submitted or considered in the initial determination. The covered person may designate a representative to file an appeal on their behalf by providing written notice that includes the issue in dispute, the covered person's signature and the representative's signature.

The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person. If the appeal involves a clinical issue, the necessity of treatment, or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of the appeal.

For appeals involving a decision based on medical necessity, the company's written response will describe the criteria or guidelines used and the clinical reasons for its decision and the option to request external review. For determinations that the services are not covered services, the response will specify the provisions in the certificate that exclude that coverage.

The covered person may obtain, upon request and free of charge, copies of all documents, records and other information relevant to the appeal.

II. The appeals process

If the covered person disagrees with a company decision regarding an authorization or a claim, the dispute shall be directed to the company either by telephone or in writing. The appeal must be filed within one-hundred-eighty (180) days of receiving a denial notice or explanation of benefits.

To initiate the standard appeal, the covered person may call the company's customer service department to request an appeal form or write the appeals department at the address below:

UnitedHealthcare Appeals & Grievances
P.O. Box 6107
Mailstop CA120-0446
Cypress, CA 90630
Fax: 1-866-704-3420

Urgent appeal: appeals involving an imminent and serious threat to the covered person's health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function, will be immediately referred to the company's clinical review personnel. Urgent appeal requests may be initiated by calling customer service or faxing a written request to the Appeals Department. If the request does not meet the criteria for an urgent appeal, it will be reviewed under the standard appeal process. If the appeal requires urgent review, the company will make a determination not later than seventy-two (72) hours of the company's receipt of the appeal.

Standard appeal: If the appeal does not qualify as an urgent appeal, it will be reviewed as a standard appeal. The Appeals Department will provide a written response regarding the outcome within thirty (30) calendar days from receipt of the appeal for an authorization denial and within sixty (60) calendar days from receipt of an appeal for a claim denial.

Independent review. If you receive and adverse determination of an appeal to the company to certify a service or procedure, the covered person or a provider acting on the covered person's behalf within sixty (60) days may file a written request with the commissioner of Connecticut Insurance Department for an independent review.

Independent reviews will be conducted in accordance with applicable state law. As part of the request, the covered person shall provide a general release for all medical records pertinent to the appeal. You will be charged a one-time $25 filing fee, unless the commissioner determines that the fee should be waived because you are indigent or unable to pay the fee. The decision of the independent review organization shall be binding on you and the company.

Non-binding arbitration is available upon request.

Quality of care/quality of service review

All quality of clinical care and quality of service complaints are investigated by the company. The company conducts reviews by investigating the complaint and consulting with treating providers and other UnitedHealthcare internal departments. Medical records are requested and reviewed as necessary and, as such, the covered person may need to sign an authorization to release medical records. The company will notify the covered person in writing regarding the disposition of the complaint within thirty (30) days of receipt of the complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

Section Five: Definitions

The company is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your certificate, as well as the schedule of benefits.

Accident means an acute injury that happens suddenly, unexpectedly and without design of the person injured. An accident does not include any activity which ordinarily would not injure a person in good health.

Acupuncture means a medically necessary treatment provided by a licensed acupuncturist that involves stimulation of anatomical points on the body by a variety of techniques.

Acupressure means a medically necessary treatment provided by a licensed provider that involves the compression of blood vessels by means of needles in surrounding tissues.

Administrator means an appropriately licensed organization with whom the company has contracted to perform administration services. Applicable administrators are identified under the administrators section of the certificate.

Alcohol, drug or other substance abuse means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to the activities of daily living on a recurring basis.

Calendar year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.

Calendar year deductible means the amount of covered expense shown on the schedule of benefits that a covered person is responsible for paying each calendar year before benefits are payable under the policy. Covered expense that a covered person has to pay due to any additional deductibles or any copayments will not be applied toward satisfying the calendar year deductible.

Certificate means this summary of the terms of your benefits, along with the schedule of benefits. The certificate is attached to and is part of the policy issued to the group policyholder and is subject to the terms of the policy.

Claim means notification in a form acceptable to the company that a covered service has been rendered or furnished to a covered person. This notification must set forth in full the details of such covered service as required by the company.

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate the conditions and manner in which a plan sponsor must offer continuation of group health insurance to covered persons whose coverage would otherwise terminate under the terms of the policy.

Cognitive rehabilitation therapy is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher level cognitive ability. This therapy is direct (one-on-one) patient contact.

Coinsurance, if any is required, means that portion of the covered expense which is not payable as a benefit due to the percentage payable being less than one hundred percent (100%). Coinsurance does not include any deductibles or copayments. Coinsurance does not include any amounts payable by the covered person which are not considered as covered expense under the policy.

Coinsurance maximum means the coinsurance maximum shown on the schedule of benefits. When a covered person has paid an amount of coinsurance during the calendar year equal to one of the coinsurance maximums, then the percentage payable will be one hundred percent (100%) for all additional covered expenses the covered person incurs during the rest of that calendar year for the type of provider for which the coinsurance maximum has been reached.

Company means UnitedHealthcare Insurance Company.

Complications of pregnancy means conditions requiring inpatient confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, puerperal infection and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy. A non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible, are considered complications of pregnancy.

Controlled drug means those drugs which contain any quantity of a substance which has been designated as subject to the federal controlled substances act, or which has been designated as a depressant or stimulant drug pursuant to federal food and drug laws, or which has been designated by the commissioner of consumer protection as having a stimulant, depressant or hallucinogenic effect upon the higher functions or the central nervous system and as having a tendency to promote abuse or psychological or physiological dependence, or both. Such controlled drugs are classifiable as amphetamine-type, barbiturate-type, cannabis-type, cocaine-type, hallucinogenic, morphine-type, and other stimulant and depressant drugs. Controlled drugs do not include alcohol, nicotine, and caffeine.

Copayment means that portion of covered expenses which is the responsibility of the covered person and which is shown as copayments on the schedule of benefits. Copayments do not apply toward the deductible and do not accrue toward the coinsurance maximum. Copayments will continue to be required after the coinsurance maximum has been reached.

Covered expense means an expense that is incurred for a Medicare eligible expense for a covered service provided to a covered person while that covered person is insured under the policy, and does not exceed the Medicare eligible expense and does not exceed the smallest of any policy maximum that may apply to the covered expense. For any other covered service under the policy which is not a Medicare eligible expense, a covered expense shall not exceed the lesser of billed charges or usual and customary charges and shall not exceed the smallest of any policy maximum that apply to the covered expense.

Covered person means the insured person or the dependent(s) of the insured person who are insured under the policy. Covered persons are sometimes called "you" and "your."

Covered service means a service or supply that is:

1. Performed, prescribed, directed or authorized by a provider; and
2. Medically necessary for the treatment of an injury or sickness.

Creditable coverage means coverage under any of the following:

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employer Retirement Income Security Act of 1974;
2. A group health benefit plan provided by a health insurance carrier or health maintenance organization;
3. An individual health insurance policy or evidence of coverage;
4. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
5. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (medical and dental care for certain members and former members of the armed services);
6. Chapter 55 of Title 10, United States Code;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A state health benefits risk pool;
9. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefit Program;
10. A public health plan (as defined in federal regulations);
11. A health benefit plan under Section 5 (e) of the Peace Corps Act; or
12. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable coverage does not include coverage consisting solely of the following:

1. Coverage only for accidents, or disability income insurance, or any combination thereof;
2. Liability insurance, or coverage issued as a supplement to liability insurance;
3. Workers' Compensation or similar insurance;
4. Automobile medical payment insurance;
5. Credit-only insurance;
6. Coverage for on-site medical clinics; or
7. Other similar insurance coverage specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable coverage does not include any of the following, if offered separately:

1. Limited scope dental or vision benefits;

2. Long term care, nursing home care, home health care, community-based care, or any combination thereof;
3. Medicare supplemental health insurance;
4. Coverage supplemental to coverage under Chapter 55 of Title 10, United States Code; or
5. Similar supplemental coverage provided to coverage under a group health plan.

Creditable coverage does not include either of the following, if offered as independent, non-coordinated benefits:

1. Coverage only for a specified disease or illness; or
2. Hospital indemnity or fixed indemnity insurance.

Custodial care means care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of custodial care by a medical professional, such as a physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained non-medical person, the services will be considered custodial care.

Deductible means the amount of covered expense a covered person must pay before benefits become payable under the policy.

Dependent means:

1. A person who is the insured person's spouse who is not legally separated from the insured person; or
2. A person who (1) is eligible for coverage under the plan sponsor's retiree welfare benefit plan; and (2) is eligible for, and enrolled in, Medicare Part A and Part B.

Dependent insurance means the group health insurance provided by the policy for dependent(s) of the insured person.

Diabetes equipment means any of the following: blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes supplies mean any of the following: test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucose emergency kits.

Drugs or prescription drugs mean only those pharmaceutical substances required by law to be dispensed by prescription.

Durable medical equipment means durable items or appliances that:

1. Are medically necessary;
2. Are able to withstand repeated use;
3. Are designed to serve a medical purpose;
4. Generally are not useful to a covered person in the absence of a medical condition, injury or sickness;
5. Are not disposable;
6. Are not customarily found in a physician's office; and
7. Are needed for functional rather than cosmetic reasons.

This term does not include charges for the repair or maintenance of such equipment.

Early intervention services means early intervention services, as defined in 34 CFR Part 303.12.

Effective date means, with respect to any covered person, the date such covered person is first insured under the policy.

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

1. Placing the covered person's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. In the case of a pregnant woman, an emergency medical condition exists if the covered person is in active labor, meaning labor at a time in which either of the following would occur:
    a. There is inadequate time to effect safe transfer to another hospital prior to delivery; or
    b. A transfer may pose a threat to the health and safety of the covered person or the unborn child.
5. The covered person accidently ingesting or consuming a controlled drug

Emergency services means covered services that are:

1. Furnished by a provider qualified to furnish emergency services; and
2. Needed to evaluate or stabilize a medical emergency. (See the definition of emergency medical condition.)

Employer means the group policyholder approved by the company for participation in the coverage provided by the policy.

Experimental and/or investigational procedures mean those particular services, supplies or treatments not covered under the policy as described in the exclusions and limitations sections of the certificate.

Facility means a health care or residential facility that is duly accredited by and licensed by the state in which it operates to provide medical inpatient, residential day treatment, partial hospitalization, skilled nursing services or outpatient care, or a facility for the diagnosis or treatment of alcohol, drug, or other substance abuse, or mental illness.

Group policyholder means the person, partnership, corporation or trust as shown on the policy information page of the policy.

Health insurance policy means insurance providing benefits due to illness or injury, resulting in loss of life, loss of earnings, or expenses incurred, and includes major medical expense coverage.

Home health aide means a person who has completed home health aide training, as required by the state in which the individual is working. Home health aides must work under a plan of care ordered by a physician and under the supervision of a licensed nurse or licensed therapist.

Home health aide services mean medically necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home health care means the home health care provided by a certified home health care agency according to a physician's written treatment plan for care of a covered person in the covered person's place of residence. Services appropriate to the needs of the individual patient are planned, coordinated and made available through a multidisciplinary health team.

Home health care agency means an organization duly licensed and certified or otherwise authorized as a home health care agency pursuant to the laws of the state in which the covered person resides and meets Medicare's requirements for home health care agencies and which is engaged in arranging and providing nursing services, home health care services, and other therapeutic and related services.

Home health care visit means up to two (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist, or up to four (4) hours of home health aide services.

Hospice means a specialized form of interdisciplinary health care for a covered person with a life expectancy of six (6) months or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a covered person who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the covered person receiving hospice services.

Hospice care means the care provided to a covered person when the goal of treatment is to provide supportive care and counseling during the terminal phase of an illness. Hospice care is provided through a hospice care agency for covered persons who have a terminal sickness, for which the prognosis of life expectancy is six (6) months or less, and who no longer elect to pursue aggressive medical treatment for the terminal sickness.

Hospital means an acute care facility operated pursuant to state laws and:

1. Is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations or by the Medicare program;
2. Is primarily engaged in providing, for compensation from its patients, diagnostic and surgical facilities for the care and treatment of injured or sick individuals by or under the supervision of a staff of physicians;
3. Has 24-hour nursing services by registered nurses; and
4. Is not primarily a place for rest or custodial care, or a nursing home, convalescent home or similar institution.

Injury means bodily injury due to an accident occurring while a covered person is insured under the terms and conditions of the policy.

Inpatient means being registered as an inpatient in a hospital or a facility upon the recommendation of a provider, and incurring charges for room and board.

Inpatient services mean those covered services provided to a covered person in a hospital or skilled nursing facility bed that is not in the outpatient department of such institution.

Insurance month means that period of time:

1. Beginning at 12:00 a.m. standard time at the group policyholder's principal location on the first day of any calendar month; and
2. Ending at 11:59 p.m. on the last day of the same calendar month.

Insured person means the retiree for whom coverage is in effect as provided by the policy.

Intensive care unit means a separate part of a hospital or facility that provides:

1. Treatment to patients in critical condition;
2. Continuous special nursing care or observation by trained and qualified personnel; and
3. Life-saving equipment.

Intramuscular means an injection into the muscle.

Intravenous means an injection into the vein.

Learning disability means a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance, and which is not a result of generalized mental retardation, educational or psycho-social deprivations, psychiatric disorder or sensory loss.

Maternity means prenatal and postnatal care, childbirth, or any complications of pregnancy of an insured person or the insured person's covered dependent spouse.

Medically necessary (or medical necessity) means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness,

injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Medicare means Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

Medicare benefit period means the period of time used by Medicare to measure your coverage under Medicare Part A. Your first benefit period begins on the day you enter a hospital as a Medicare patient. It ends sixty (60) days after you leave the hospital (counting the day of your discharge) or, if you have to go from the hospital to a skilled nursing facility, it ends sixty (60) days after you leave the skilled nursing facility. If you are hospitalized again within sixty (60) days, the second hospital stay is considered part of your first Medicare benefit period.

Medicare eligible expense means expenses of the kind covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. Payment of benefits under the policy for Medicare eligible expenses will be based on the same payment conditions and determinations of medical necessity as are applicable under Medicare.

Medicare Part A or Part B deductible means the amount of health care charges Medicare requires you to pay before Medicare Part A or Part B benefits are paid.

Medicare Part B excess charges means the difference between the actual Medicare Part B approved amount and the Medicare-approved Part B charge for non-assigned claims. The billed charges must not exceed any limitation established by Medicare or state law.

Mental retardation and related conditions means conditions based on the following three criteria: intellectual functioning level (IQ) is below 70–75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less.)

Neuromuscular skeletal disorders means misalignments of skeletal structures and muscular weaknesses, imbalance and disorders related to the spinal cord, neck and joints. All such disorders must be documented and demonstrated through X-rays or bodily function limitations.

Occupational therapy means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a licensed physician who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility.

Open enrollment period means a period of time as specified in the application of the group policyholder and approved by the company during which retirees may enroll themselves and their eligible dependents under the policy. The open enrollment period, if any, is shown on the policy information page.

Ostomy means an operation to create an artificial passage for bodily elimination, inclusive of colostomy, ileostomy and urostomy.

Out-of-pocket expense maximum, if any, is shown on the schedule of benefits. When a covered person has paid an amount during the plan year equal to the out-of-pocket expense maximum excluding pharmacy coinsurance, then the percentage payable will be one hundred percent (100%) for all additional covered expenses the covered person incurs during the rest of that plan year.

Outpatient means receiving treatment from a provider in a facility other than on an inpatient basis.

Pain means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves.

Pain management specialist means a physician whom is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

Partial hospitalization means a formal program of care provided in a hospital or facility for periods of less than twenty-four hours a day.

Percentage payable means the benefits payable under the policy which are a percentage of the covered expense in excess of all deductibles and copayments. The percentage payable for each type of covered service is set forth in the schedule of benefits.

Personal insurance means the group health insurance provided by the policy on insured persons.

Physician means a licensed doctor of allopathy or osteopathy who is practicing within the scope of his or her licensure and any other practitioner of the healing arts who renders services within the scope of his or her licensure.

Plan year means any consecutive twelve-month period beginning on the effective date shown in the policy.

Policy means the group health insurance policy issued by the company to the group policyholder.

Policy anniversary means the annual date stated as the "policy anniversary" on the policy information page of the policy.

Policy effective date means the date stated as the "policy effective date" on the policy information page of the policy.

Provider means a person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this certificate and any supplemental benefit materials.

Rehabilitation services mean the individual or combined and coordinated use of medical, physical, cognitive rehabilitation, occupational and speech therapy for training or retraining individuals disabled by sickness or injury.

Respite care means the short-term services provided to covered persons receiving authorized hospice services who have disabilities that require care and/or supervision while allowing the caregivers temporary relief. Services may be provided:

1. In a nursing home or hospital, and includes personal care, nursing intervention, supervision, meal preparation, and a room.

2. In an adult foster care home or personal care home, and includes personal care, housekeeping, supervision, meal preparation, transportation, and a room.
3. In an adult day health care facility, and includes personal care, nursing services, supervision, meal preparation, and transportation.
4. In the individual's own home by a home care attendant or primary caregiver, and includes personal care, housekeeping, meal preparation, supervision, and transportation.

Retiree means someone who: (1) has met all the eligibility requirements established by the employer for participation in the employer's retiree welfare benefit plan; (2) is age 65 or older; (3) is eligible for, and enrolled in, Medicare Part A and Part B; and (4) who is entitled to benefits under the policy.

Semi-private room rate means the most common charge for a two-bed room in a hospital, facility, or skilled nursing facility, as determined by the company.

Sickness means a physical illness, disease or complications of pregnancy.

Skilled nursing facility means a comprehensive freestanding rehabilitation facility or a specially designed unit within a hospital licensed by the state in which it is doing business to provide skilled nursing services.

Skilled nursing services mean the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide.

Skilled rehabilitation care means the care provided directly by or under the direct supervision of a licensed provider acting within the scope of his or her licensure.

Special enrollment period means a period of time, mandated by the Health Insurance Portability and Accountability Act of 1996, where persons or dependents who are not insured under the policy may enroll for coverage as specified in the special enrollment provision.

Spouse means a legally recognized husband or wife under the laws of the state where the policy is delivered.

Subacute and transitional care means levels of care needed by a covered person who does not require hospital acute care, but who requires more intensive licensed skilled nursing services than are provided to the majority of patients in a skilled nursing facility.

Subcutaneous means an injection under the skin.

Temporomandibular joint dusfunction means a condition affecting the upper or lower jawbone, or associated bone joints that is unrelated to any external traumatic episode.

Telehealth means a health service, other than a telemedicine service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;

2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine means professional services given a covered person through an interactive telecommunication system by a provider at a distant site.

Urgent care means covered services rendered at an urgent care facility which are appropriate to the treatment of an injury or sickness that is not an emergency medical condition, but requires prompt medical attention. Urgent care includes the treatment of minor injuries as a result of accidents, the relief or elimination of acute pain, or the moderation of an acute sickness.

Usual and customary charge means the lesser of:

1. A provider's usual charge for furnishing treatment, service or a supply; or
2. The charge the company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same area and whose injury or sickness is comparable in nature and severity.

We, our, us and company mean UnitedHealthcare Insurance Company.

You and your mean the insured person.

Section Six: General Provisions

Certificate. Each covered person will have available an individual certificate and a schedule of benefits. The certificate and schedule of benefits summarize the benefits provided by the policy. If there is a conflict between the policy and the certificate, the policy will control.

Clerical error. Clerical error does not invalidate insurance otherwise validly in force, nor continue insurance otherwise validly terminated. Neither the passage of time nor the payment of premiums for a person who is not eligible for insurance under the terms of the policy makes this insurance valid for such person. In this event, the company's only liability is the proper refund of unearned premiums. If a premium adjustment requires the refund of unearned premium, the maximum refund is the six (6)-month period preceding the date the company receives proof of the adjustment. The company can request such information while the policy is in force and for one (1) year after the policy ends.

Conformity to state and federal law. The company amends any provision of the policy that conflicts with state or federal law on the policy effective date to the minimum requirements of the law.

Group policyholder not our agent. The group policyholder is not an agent of the company.

Provider as independent agent. The company does not undertake to directly furnish any health care service under the policy. The obligations of the company under the policy are limited to the payment for health care service provided to covered persons by providers who are independent agents.

Medical records. The company shall have access to medical and treatment records of covered persons to determine benefits, process claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to the policy benefits. Each covered person shall complete and submit to the company such additional consents, releases and other documents as may be requested by the company in order to determine or provide benefits under the policy. The company reserves the right to reject or suspend a claim based on lack of supporting medical information or records.

Recovery of payments. The company reserves the right to deduct from any benefits properly payable under the policy the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a claim;
3. Pursuant to a misstatement made to obtain coverage under the policy within two (2) years after the date such coverage commences;
4. With respect to an ineligible person; or
5. Pursuant to a claim for which benefits are recoverable under any policy or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recoverable. This provision shall not be deemed to require the company to pay benefits under the policy in any such instance.

Such deduction may be made against any claim for benefits under the policy by a covered person if such payment is made with respect to such covered person.

Discharge of liability. Any payment made in accordance with the provisions of the policy shall fully discharge the liability of the company to the extent of such payment.

Right to receive information. The group policyholder shall provide the company with the information necessary to administer coverage under the policy. Payroll and any other records of an insured person relating to coverage under the policy shall be open for review by the company at any reasonable time. The company may request that information needed to compute the premium be furnished at least once each year.

Time effective. Whenever an effective date of coverage or termination date of coverage is specified by the policy, such commencement of coverage will be effective as of 12:00 a.m. of that date.

Waiver of rights. The company's failure to enforce any provision of the policy does not affect our right to enforce any provision at a later date, and does not affect the company's right to enforce any other provision of the policy.

Note: This certificate constitutes only a summary of the benefits available under the plan sponsor's plan. The policy between the company and the group policyholder must be consulted to determine the exact terms and conditions of coverage. A copy of the policy will be furnished upon request and is available at UnitedHealthcare Insurance Company and your plan sponsor's personnel office.