UnitedHealthcare Choice EDGE

UnitedHealthcare of New England, Inc.

Schedule of Benefits

Gold Plan

Accessing Benefits

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

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

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

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

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

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

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

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

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. In addition, you may request prior authorization as suggested within the *Schedule of Benefits* table. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, ground and water.
- Clinical trials.
- Dental services - accidental.
- Infertility services.
- Obesity surgery.
- Transplants.

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

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

Care Management

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

Special Note Regarding Medicare

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

Benefits

Annual Deductibles are calculated on a Policy year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Copayment.	***Designated Network and Network*** $1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.
Per Occurrence Copayment	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Copayment.	When a Per Occurrence Copayment applies, it is listed below under each Covered Health Service category.

Payment Term And Description	Amounts
• The Eligible Expense.	
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Copayment, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this Schedule of Benefits, including Covered Health Services provided under the *Outpatient Prescription Drug Services* section of the *Certificate.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	***Designated Network and Network*** $3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. The Out-of-Pocket Maximum includes all Per Occurrence Copayments.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Acupuncture Services			
Limited to 10 treatments per year.	100% after you pay a Copayment of $60 per visit	Yes	No
2. Ambulance Services			
Prior Authorization In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, we suggest that you confirm authorization as soon as possible prior to transport.			
Emergency Ambulance	*Ground Ambulance:* 100% after a Copayment of $50 per transport *Air or Water Ambulance:* 100%	Yes Yes	No Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100% after a Copayment of $50 per transport *Air or Water Ambulance:* 100%	Yes Yes	No Yes
3. Clinical Trials			
Prior Authorization We suggest you obtain prior authorization as soon as the possibility of participation in a clinical trial arises.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
4. Congenital Heart Disease Surgeries			
	100% after you pay a Per Occurrence Copayment of $500 per Inpatient Stay	Yes	Yes
5. Dental Services - Accident Only			
Prior Authorization We suggest you obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (Prior authorization does not have to be obtained before the initial Emergency treatment.)			
	100%	Yes	Yes
6. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under the *Durable Medical Equipment* and *Outpatient Prescription Drug Services* sections of the *Certificate.*		
7. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
8. Early Intervention Services			

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	100%	No	No
9. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	100% after you pay a Copayment of $200 per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	Yes	No
10. Enteral Nutrition Products			
	100%	Yes	Yes
11. Hearing Aids			
Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	100%	Yes	Yes
12. Home Health Care			
	100%	Yes	Yes
13. Hospice Care			
	100%	Yes	Yes

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
14. Hospital - Inpatient Stay			
	100% after you pay a Per Occurrence Copayment of $500 per Inpatient Stay	Yes	Yes
15. Infertility Services			
Prior Authorization We suggest you obtain prior authorization as the possibility of the need for Infertility Services arises.			
	100%	Yes	Yes
16. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient: **X-Ray and Other Diagnostic Testing - Outpatient:**	100% 100%	Yes Yes	No No
17. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
18. Lyme Disease			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Mental Health Services			
	Inpatient 100% after you pay a Per Occurrence Copayment of $500 per Inpatient Stay *Outpatient* 100% after you pay a Copayment of $60 per visit	Yes Yes	Yes No

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
20. Neurobiological Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% after you pay a Per Occurrence Copayment of $500 per Inpatient Stay *Outpatient* 100% after you pay a Copayment of $60 per visit	Yes Yes	Yes No
21. Nutritional Counseling			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
22. Obesity Surgery			
Prior Authorization We suggest you obtain prior authorization must be obtained as soon as the possibility of obesity surgery arises **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Obesity surgery must be received at a Designated Facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
23. Orthotic Devices			
Benefits are limited to a single purchase of a type of orthotic device (including repair/replacement) every three years. You must purchase or rent the orthotic device from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
24. Ostomy Supplies			
	100%	Yes	Yes

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
25. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
26. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	***Designated Network*** 100% ***Network*** 100% for Covered Health Services from a Primary Physician 80% for Covered Health Services from a Specialist Physician	Yes Yes	Yes Yes
27. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient*	***Designated Network*** 100% after you pay a Copayment of $30 per visit for a Primary Physician office visit or $30 per visit for a Specialist Physician office visit ***Network*** 100% after you pay a Copayment of $30 per visit for a Primary Physician office visit or $60 per visit for a Specialist Physician office visit	Yes Yes	No No

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Diagnostic and Therapeutic. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.			
28. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
29. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
30. Prosthetic Devices			
	100%	Yes	Yes
31. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
32. Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment			
Visit limits per year: • Unlimited physical therapy visits. • Unlimited occupational therapy	100% after you pay a Copayment of $30 per visit	Yes	No

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
visits. • Unlimited speech therapy visits. • 20 Manipulative Treatments (including Chiropractic services). • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive therapy.			
33. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
	100%	Yes	Yes
35. Substance Use Disorder Services			
	Inpatient 100% after you pay a Per Occurrence Copayment of $500 per Inpatient Stay *Outpatient* 100% after you pay a Copayment of $60 per visit	Yes Yes	Yes No
36. Surgery - Outpatient			
	100% after you pay a Per Occurrence Copayment of $250 per date of service	Yes	Yes
37. Therapeutic Treatments - Outpatient			

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	100%	Yes	Yes
38. Tobacco Cessation Treatment - Outpatient			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
39. Transplantation Services			
Prior Authorization Requirement We suggest you obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
40. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*.	100% after you pay a Copayment of $75 per visit	Yes	No

When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.			
41. Vision Examinations			
Limited to one exam per year for Covered Persons 19 years of age and older	100% after you pay a Copayment of $30 per visit	Yes	No
42. Wigs			
	100%	Yes	No

Eligible Expenses

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

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

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

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

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

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

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

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

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

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

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

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

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

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

Provider Network

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

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

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

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

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

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

Pediatric Vision Care Services Schedule of Benefits

UnitedHealthcare of New England, Inc.

Benefits for Pediatric Vision Care Services

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

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

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Copayments at the time of service.

Benefit limits are calculated on either a calendar of Policy year basis as applicable unless otherwise specifically stated.

Benefits:

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

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

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Schedule are subject to any Annual Deductible stated in the *Schedule of Benefits.* Any amount you pay in Copayments for Vision Care Services under this Schedule does not apply to the Annual Deductible stated in the *Schedule of Benefits.*

Frequency of Service Limits

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

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $30. Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once per year.	
• *Single Vision*		50%
• *Bifocal*		50%
• *Trifocal*		50%

• *Lenticular*		50% Not subject to payment of the Annual Deductible.
• *Polycarbonate*		100%
• *Standard Scratch-resistant coating*		100%
• *Each of the following is a separate charge:* ▪ *Blended segment lenses,* ▪ *Intermediate vision lenses.* ▪ *Standard Progressives.* ▪ *Premium Progressives* ▪ *Photochromic Glass* ▪ *Plastic Photosensitive* ▪ *Polarized* ▪ *Hi-Index* ▪ *Standard Anti-Reflective Coating* ▪ *Premium Anti-Reflective Coating* ▪ *Ultra Anti-Reflective Coating* ▪ *UV Coating*		20% of the billed charge.
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		50%
• *Eyeglass frames with a retail cost of $130 - 160.*		50%
• *Eyeglass frames with a retail cost of $160 - 200.*		50%

• *Eyeglass frames with a retail cost of $200 - 250.*		50%
• *Eyeglass frames with a retail cost greater than $250.*		50%
Vision Care Service	**Frequency of Service**	**Benefit**
Contact Lenses Fitting & Evaluation	Once per year.	
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	50%
• *Necessary Contact Lenses*	Limited to a 12 month supply.	50%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Limited to once every 24 months, or every 6 months when low vision conditions occur.	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

Outpatient Prescription Drug

UnitedHealthcare of New England, Inc.

Schedule of Benefits

Benefits for Prescription Drug Products

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

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

If prior authorization is not obtained from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

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

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

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

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

Step Therapy

Certain Prescription Drug Products for which Benefits are described under the *Outpatient Prescription Drug Services* section of your *Certificate* or for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

What You Must Pay

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

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

The amount you pay for any of the following under this *Schedule of Benefits* will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

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

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Prescription Drug Products**	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

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

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy or a mail order Network Pharmacy.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $20 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $60 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $100 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $20 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $70 per Prescription Order or Refill.

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medication. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drug Products. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, and Tier 3. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For up to a 90-day supply, we pay: For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $100 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $175 per Prescription Order or Refill.