UnitedHealthcare
Contraceptive Services Only

Group Number: 755733

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries: Call the number on the back of your Contraceptives Services Only ID Card
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: www.myuhc.com

IMPORTANT: UnitedHealthcare Contraceptive Services Only Benefit is a limited Benefit. United HealthCare Services, Inc. ("UnitedHealthcare ") has arranged for direct payment of contraceptive services and supplies in the place of an Eligible Organization.

UnitedHealthcare is pleased to provide you with this Booklet, which describes the health Benefits available to you and your covered family members under the Contraceptive Services Only Benefit. UnitedHealthcare is serving as Claims Administrator for this Benefit. UnitedHealthcare is funding this Benefit. This is not an insured Benefit coverage.

The Booklet includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Contraceptive Services Only Benefit.

This Booklet is designed to meet your information needs. It supersedes any previous printed or electronic Booklet for this Contraceptive Services Only Benefit.

[IMPORTANT

The healthcare service, supply or Preventive Care Medication is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 11, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Contraceptive Services Only Benefit.]

UnitedHealthcare intends to continue this coverage, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the coverage at any time, for any reason, and without prior notice. This Booklet is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this Booklet and, the contents of any other document, your rights shall be determined under the Booklet.

Please read this Booklet thoroughly to learn how the Benefit works. If you have questions call the number on the back of your Contraceptive Services Only ID card.

How To Use This Booklet

- Read the entire Booklet, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your Booklet and any future amendments at **www.myuhc.com** or request printed copies by contacting the Claims Administrator.
- Capitalized words in the Booklet have special meanings and are defined in Section 11, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 11, *Glossary*.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Contraceptive Services Only Benefit;
- When coverage begins and ends.

Eligibility

You and your dependents are eligible for the Contraceptive Services Only Benefit if you and your dependents are enrolled in an Eligible Organization's base medical and prescription drug plan where UnitedHealthcare or one of its affiliates is also the Claims Administrator for the Eligible Organization's base medical and prescription drug plan.

When the Contraceptive Services Only Benefit Begins and Ends

You and your dependents' coverage will begin and end as described in the Eligible Organization's base medical and prescription drug plan documents or as otherwise described in this document.

SECTION 3 - HOW THE CONTRACEPTIVE SERVICES ONLY BENEFIT WORKS

What this section includes:
- Benefits;
- Eligible Expenses.

Accessing Benefits

You must obtain services or supplies from a [Network Provider] [and] [[2]Network Pharmacy] in order to obtain the Benefits described in this Booklet.

You are eligible for Benefits under this Contraceptive Services Only Benefit when you receive Covered Health Services from Physicians and Pharmacies who have contracted with the Claims Administrator to provide those services. Except as specifically described within the Booklet, Benefits are not available for services provided by a non-Network provider or non-Network Pharmacy. This Benefit coverage does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Pharmacy prescribed to prevent conception or a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network facility-based radiologist, anesthesiologist, pathologist, or assistant at surgery who provides services to Covered Persons only incidental to facility services or who furnishes services only under the direct supervision of a Network Physician.

Network Providers

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator will send you a directory of network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call the Claims Administrator at the toll-free number on your Contraceptive Services Only ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of UnitedHealthcare.

Looking for a Network Provider?
In addition to other helpful information, www.myuhc.com, the Claims Administrator's consumer website, contains a directory of health care professionals and facilities in the Claims Administrator's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Contraceptive Services Only Benefit.

Please access www.myuhc.com through the Internet or call the telephone number on your Contraceptive Services Only ID card to determine if Benefits are provided for your Preventive Care Medication and for information on how to obtain your Preventive Care Medication through a Network Pharmacy.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Possible Limitations on Selection of Pharmacies

If UnitedHealthcare determines that you are using a Preventive Care Medication in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Pharmacy for you. In the event that you do not use the Network Pharmacy to coordinate all of your care, any Covered Health Services you receive will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Contraceptive Services Only Benefit is in effect, determined according to the definition in Section 11, *Glossary*. UnitedHealthcare has the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered.

Don't Forget Your Contraceptive Services Only ID Card
Remember to show your Contraceptive Services Only ID card every time you receive contraceptive services from a Network provider or visit a Network Pharmacy to obtain contraceptives. If you do not show your Contraceptive Services Only ID card, a Network provider has no way of knowing that you are eligible for the Contraceptive Services Only Benefit. Note that your Contraceptive Services Only ID card is different from your health plan ID card that applies to the base medical and prescription drug plan provided, paid or arranged for by the Eligible Organization through the Claims Administrator or one of its affiliates. To obtain a copy of your Contraceptive Services Only ID card, contact us at the phone number listed on the back of the medical ID card.

There is no cost to the Covered Persons under the Contraceptives Services Only Benefit. You will not have a copayment, coinsurance or annual deductible to satisfy in order to

obtain the Benefits described in this Booklet. UnitedHealthcare pays 100% of the cost for the Benefits described in this Booklet.

SECTION 4 - COVERAGE HIGHLIGHTS AND ADDITIONAL COVERAGE DETAILS

This section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply. Services that are not covered are described in Section 5, *Exclusions*.

This table provides an overview of the coverage levels.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Claims Administrator:
Outpatient Contraceptive Services and Supplies	100%
Preventive Care Medications Coverage for Contraceptive Supplies ■ **Retail** - up to a 31-day supply	100%

[1]There will be no annual deductible, annual out-of-pocket maximum or lifetime maximum applied to this Benefit.

Outpatient Contraceptive Services and Supplies

This Contraceptive Services Only Benefit covers only contraceptive services and supplies which:

- are preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital,
- are required to be covered under the federal Patient Protection and Affordable Care Act, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, and
- are Covered Health Services that are not otherwise covered by the medical benefits provided, paid or arranged for by your Eligible Organization through the Claims Administrator or one of its affiliates.

Preventive Care Medications Benefit for Contraceptive Supplies

Benefits under this Contraceptive Services Only Benefit are available for Preventive Care Medications prescribed to prevent conception, including but not limited to, oral contraceptives and diaphragms.

The Contraceptive Services Only Benefit's coverage of Preventive Care Medications only applies when you have a prescription filled at a Network Pharmacy.

See Section 12, *Preventive Care Medications*, for coverage details.

For questions about your Contraceptive Services Only Benefits under this Booklet call the number on the back of your Contraceptive Services Only ID card.

SECTION 5 - EXCLUSIONS: WHAT IS NOT COVERED

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 4, *Coverage Highlights and Additional Coverage Details*.

The Contraceptive Services Only Benefit does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

Please note that in listing services or examples, when the Booklet says "this includes," or "including but not limiting to", it is not the Claims Administrator's intent to limit the description to that specific list. When the Booklet does intend to limit a list of services or examples, the Booklet specifically states that the list "is limited to."

Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 11, *Glossary*. Covered Health Services are those contraceptive health services including contraceptive services, contraceptive supplies or Preventive Care Medications, which UnitedHealthcare determines to be all of the following:

   - Medically Necessary;
   - described as a Covered Health Service in Section 4, *Coverage Highlights and Additional Coverage Details* in this Booklet;
   - provided to a Covered Person who meets the Eligible Organization's eligibility requirements, as described under Eligibility in Section 2, *Introduction*; and
   - not otherwise excluded in this Booklet under this Section 5, *Exclusions*.

2. Health services related to a non-Covered Health Service. When a service is not a Covered Health Service, all services related to that non-Covered Health Service.

3. Health services covered under the base medical and prescription drug plan provided, paid or arranged for by the Eligible Organization through the Claims Administrator or one of its affiliates.

4. The Contraceptive Services Only Benefit does not provide reimbursement or coverage for medical complications that might arise out of the provision of Covered Health Services under this Contraceptives Services Only Benefit. See your underlying medical plan document for information about your rights in these circumstances.

5. Outpatient Contraceptive Services and Supplies do not include prescription drug products for outpatient use that are filled by a prescription order or refill, self-injectable medications, or over-the-counter contraceptives, whether prescribed or not.

6. Outpatient Contraceptive Services and Supplies provided for any condition other than to prevent conception.

7. Preventive Care Medications prescribed for any condition other than to prevent conception. In addition, the exclusions listed below apply:

   - any Preventive Care Medication for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
   - Pharmaceutical products for which Benefits are provided in the medical (not in Section 12, Preventive Care Medications) portion of the Contraceptive Services Only Benefit;

   This exclusion does not apply to Depo Provera and other injectable drugs used for contraception which are covered under the medical portion of the Contraceptive Services Only Benefit.

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

When an exclusion applies to only certain contraceptives, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your Contraceptive Services Only ID card for information on which contraceptives are excluded.

SECTION 6 - CLAIMS PROCEDURES

What this section includes:
- How claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Claims Administrator will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service, please contact the provider or call the Claims Administrator at the phone number on your Contraceptive Services Only ID card for assistance.

Preventive Care Medication Benefit Claims

If you wish to receive reimbursement for a Preventive Care Medication, you may submit a post-service claim as described in this section if you are asked to pay the full cost of the Preventive Care Medication when you fill it and you believe that the Contraceptive Services Only Benefit should have paid for it.

If a pharmacy fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

When you obtain services or supplies directly and a Provider does not file the claim you will need to submit a claim for reimbursement. You can obtain a claim form by visiting **www.myuhc.com**, or calling the toll-free number on your Contraceptive Services Only ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participants;
- the number as shown on your Contraceptive Services Only ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician, if applicable;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began, if applicable; and

- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance coverage or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your Contraceptive Services Only ID card.

When filing a claim for Preventive Care Medication Benefits, submit your claim to the pharmacy benefit manager claims address noted on your Contraceptive Services Only ID card.

After the Claims Administrator has processed your claim, you will receive payment for Benefits as allowed under this Booklet.

The Claims Administrator will pay Benefits to you unless:

- the provider notifies the Claims Administrator that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the provider to be paid directly at the time you submit your claim.

The Claims Administrator will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Explanation of Benefits (EOB)

You may request that the Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your Contraceptive Services Only ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 11, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Claims Administrator will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Claims Administrator. This 12-month requirement does not apply if you are legally incapacitated.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at the number on your Contraceptive Services Only ID card before requesting a formal appeal.

If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the Contraceptive Services Only ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
Central Escalations Unit
P.O. Box 30573
Salt Lake City, UT 84130-0573

For urgent care requests for Benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your Contraceptive Services Only ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination. The process is available at no charge to you.

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

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

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

An external review request should include all of the following:

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

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

- a standard external review; and
- an expedited external review.

Standard External Review

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

- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and
- a decision by the IRO.

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

- is or was a Covered Person at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

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

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

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

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

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

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

Expedited External Review

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

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

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

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

- is or was a Covered Person at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in

making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

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

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

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- urgent care request for Benefits- a request for Benefits provided in connection with urgent care services;
- Pre-Service request for Benefits - a request for Benefits which the Claims Administrator must approve or in which you must obtain prior authorization from UnitedHealthcare before non-urgent care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Claims Administrator denies your request for Benefits,	**180 days** after

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
you must appeal an adverse benefit determination no later than:	receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Claims Administrator, you must do so within one year from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Claims Administrator.

You cannot bring any legal action against the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Claims Administrator you must do so within one year of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Claims Administrator.

Any legal action brought against the Claims Administrator shall be limited to value of the Contraceptives Only Benefit.

SECTION 7- COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Contraceptive Services Only Benefit coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event that the Claims Administrator overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- an employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Contraceptive Services Only Benefit will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving continuation coverage under an employer plan that is not provided by the Eligible Organization, this Contraceptive Services Only Benefit will not pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;

- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans. In addition, this Contraceptive Services Only Benefit will not pay more than it would have paid had it been the primary plan.

When This Contraceptive Services Only Benefit is Secondary

If this Contraceptive Services Only Benefit is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Contraceptive Services Only Benefit determines the amount it would have paid based on the allowable expense.
- if the Contraceptive Services Only Benefit would have paid less than the primary plan paid, the Contraceptive Services Only Benefit pays no Benefits.
- if the Contraceptive Services Only Benefit would have paid more than the primary plan paid, the Contraceptive Services Only Benefit will pay the difference.

The maximum combined payment you may receive from all coverage may be less than 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Contraceptive Services Only Benefit is secondary and the expense meets the definition of a Covered Health Service under this Contraceptive Services Only Benefit, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. Nothing in this paragraph shall be construed to provide Benefits for services provided by non-Network providers, unless such coverage is otherwise required under this Contraceptive Services Only Benefit.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Contraceptive Services Only Benefit.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Contraceptive Services Only Benefit will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Contraceptive Services Only Benefit pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time; and
- disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Contraceptive Services Only Benefit is Secondary to Medicare

If this Contraceptive Services Only Benefit is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with the Benefits under this Booklet, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Contraceptive Services Only Benefit is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Contraceptive Services Only Benefit and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. When calculating the Contraceptive Services Only Benefit's secondary Benefits in these circumstances, for administrative convenience United in its sole discretion may treat the provider's billed charges as the allowable expense for both the Contraceptive Services Only Benefit and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Contraceptive Services Only Benefit and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Contraceptive Services Only Benefit and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Contraceptive Services Only Benefit must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the Contraceptive Services Only Benefit may pay the other plan the amount owed.

If the Contraceptive Services Only Benefit pays you more than it owes under this COB provision, you should pay the excess back promptly. The Claims Administrator reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Contraceptive Services Only Benefit overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If UnitedHealthcare pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to UnitedHealthcare if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment UnitedHealthcare made exceeded the Benefits under the Contraceptive Services Only Benefit; or
- all or some of the payment was made in error.

The refund equals the amount UnitedHealthcare paid in excess of the amount that should have been paid under the Contraceptive Services Only Benefit. If the refund is due from another person or organization, the Covered Person agrees to help UnitedHealthcare get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, UnitedHealthcare may reduce the amount of any future Benefits for the Covered Person that are payable under the Contraceptive Services Only Benefit. The

reductions will equal the amount of the required refund. UnitedHealthcare may have other rights in addition to the right to reduce future Benefits.

SECTION 8 - RIGHT OF RECOVERY AND REIMBURSEMENT

Right of Recovery

The Claims Administrator also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Claims Administrator provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Claims Administrator will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

The Claims Administrator has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Claims Administrator; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Claims Administrator.

SECTION 9 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.

Your entitlement to Benefits automatically ends on the date that coverage ends under the base medical and prescription drug plan provided, paid or arranged for by the Eligible Organization from or through the Claims Administrator, even if you are hospitalized or are otherwise receiving medical treatment on that date. If the plan provided, paid or arranged for by the Eligible Organization from or through the Claims Administrator covers both medical services and prescription drugs, and your coverage for prescription drugs under that plan ends but your coverage for medical services continues, then your coverage for Preventive Care Medications under this Booklet will end and your coverage for outpatient contraceptive services and supplies under this Booklet will continue. If the plan provided, paid or arranged for by the Eligible Organization from or through the Claims Administrator covers both medical services and prescription drugs, and your coverage for medical services under that plan ends but your coverage for prescription drugs continues, then your coverage for outpatient contraceptive services and supplies under this Booklet will end and your coverage for Preventive Care Medications under this Booklet will continue.

When your coverage ends, the Claims Administrator will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your and your eligible dependents' Contraceptive Services Only Benefit will end as described Eligible Organization's base medical and prescription drug plan documents.

Other Events Ending Your Coverage

The Claims Administrator will provide prior written notice to you that your Contraceptive Services Only Benefit will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to the Claims Administrator's staff, a provider or another Covered Person; or
- the Claims Administrator no longer has a legal obligation to provide the coverage described under this Contraceptive Services Only Benefit.

Note: The Claims Administrator has the right to demand that you pay back Benefits the Claims Administrator paid to you, or paid in your name, during the time you were incorrectly covered under the Contraceptive Services Only Benefit.

SECTION 10 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with the Claims Administrator;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Contraceptive Services Only Benefit; and
- How to access the official Contraceptive Services Only Benefit documents.

Your Relationship with the Claims Administrator

In order to make choices about your health care coverage and treatment, it is important for you to understand how the Claims Administrator interacts with the Eligible Organization and how it may affect you. The Claims Administrator provides or helps administer the Eligible Organization's base medical and prescription drug plan in which you are enrolled. The Claims Administrator also helps administer and arrange for payment, at no cost to you, of the Benefits described under the Contraceptive Services Only Benefit. The Claims Administrator does not provide medical services or make treatment decisions. This means:

- the Claims Administrator does not decide what care you need or will receive. You and your Physician make those decisions;
- the Claims Administrator communicates to you decisions about whether the Contraceptive Services Only Benefit will cover or pay for the health care that you may receive (the Contraceptive Services Only Benefit pays for Covered Health Services, which are more fully described in this Booklet); and
- the Contraceptive Services Only Benefit may not pay for all treatments you or your Physician may believe are necessary. If the Contraceptive Services Only Benefit does not pay, you will be responsible for the cost.

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

Relationship with Providers

The relationships between the Eligible Organization, the Claims Administrator and Network providers are solely contractual relationships between independent contractors. Network providers are not agents or employees of the Eligible Organization, nor are they agents or employees of the Claims Administrator. The Eligible Organization and any of its employees are not agents or employees of Network providers, nor are the Claims Administrator and any of its employees' agents or employees of Network providers.

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

The Claims Administrator is not considered to be an employer of the Eligible Organization for any purpose with respect to the administration or provision of benefits under this Coverage.

The Eligible Organization is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your base medical and prescription drug plan coverage, which drives enrollment in this Contraceptive Services Only Benefit); and
- notifying you of the termination or modifications to the base medical and prescription drug plan coverage which drives enrollment, termination or modifications in this Contraceptive Services Only Benefit.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The Claims Administrator has the sole and exclusive discretion to:

- interpret Benefits under the Contraceptive Services Only Benefit;
- interpret the other terms, conditions, limitations and exclusions of the Contraceptive Services Only Benefit, including this Booklet and any Riders and/or Amendments; and

- make factual determinations related to the Contraceptive Services Only Benefit and its Benefits.

The Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Contraceptive Services Only Benefit.

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

Information and Records

The Claims Administrator may use your individually identifiable health information to administer the Contraceptive Services Only Benefit and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Contraceptive Services Only Benefit, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons. The Claims Administrator agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Contraceptive Services Only Benefit, for appropriate medical review or quality assessment, or as the Claims Administrator is required to do by law or regulation. During and after the term of the Contraceptive Services Only Benefit, the Claims Administrator and its related entities may use and transfer the information gathered under the Contraceptive Services Only Benefit in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

In some cases, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

Incentives to Providers

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your Contraceptive Services Only ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the Claims Administrator recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your Contraceptive Services Only ID card if you have any questions.

Rebates and Other Payments

The Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. The Claims Administrator does not pass these rebates on to you.

Workers' Compensation Not Affected

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

Future of the Contraceptive Services Only Benefits

The Claims Administrator reserves the right to discontinue, alter or modify the Contraceptive Services Only Benefit in whole or in part, at any time and for any reason, at its sole determination.

The Claims Administrator's decision to terminate or amend the Contraceptive Services Only Benefit may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason.

If this Contraceptive Services Only Benefit is terminated, Covered Persons will not have the right to any other Benefits from the Contraceptive Services Only Benefit, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Contraceptive Services Only Benefit. In addition, if the Contraceptive Services Only Benefit is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Contraceptive Services Only Benefit document or contract provisions affecting the Contraceptive Services Only Benefit and Claims Administrator decisions.

Coverage Document

This Booklet represents an overview of your Benefits and is the official coverage document. You (or your personal representative) may obtain a copy of this document by written request to the Claims Administrator at the address on the back of your Contraceptive Services Only ID card.

SECTION 11 – GLOSSARY

What this section includes:
- Definitions of terms used throughout this Booklet.

Many of the terms used throughout this Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Contraceptive Services Only Benefit is administered and how Benefits are paid. This section defines terms used throughout this Booklet, but it does not describe the Benefits provided by the Contraceptive Services Only Benefit.

Addendum – any attached written description of additional or revised provisions to the Contraceptive Services Only Benefit. The benefits and exclusions of this Booklet and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Booklet and/or Amendments to the Booklet, the Addendum shall be controlling.

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

- Surgical services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Amendment – any attached written description of additional or alternative provisions to the Coverage. Amendments are effective only when distributed by the Claims Administrator. Amendments are subject to all conditions, limitations and exclusions of the Contraceptive Services Only Benefit, except for those that the amendment is specifically changing.

Benefits – Contraceptive Services Only Benefit payments for Covered Health Services, subject to the terms and conditions of the Contraceptive Services Only Benefit and any Addendums and/or Amendments.

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Contraceptive Services Only Benefit.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Covered Health Services – those contraceptive health services, including contraceptive services, contraceptive supplies and Preventive Care Medications, which UnitedHealthcare determines to be:

- Medically Necessary;
- included in Section 4, *Coverage Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Eligible Organization's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and

- not identified in Section 5, *Exclusions*.

Covered Person – either the Participants or an enrolled Dependent only while enrolled and eligible for Benefits under the Eligible Organization's base medical and prescription drug plan. References to "you" and "your" throughout this Booklet are references to a Covered Person.

Dependent – an individual who meets the eligibility requirements specified in the Eligible Organization's base medical and prescription drug plan, as described under *Eligibility* in Section 2, *Introduction*.

Eligible Expenses – charges for Covered Health Services that are provided while the Coverage is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Eligible Organization – The nonprofit religious organization with religious objections to covering contraceptive services that self-certifies compliance, as prescribed by rules issued under the federal Patient Protection and Affordable Care Act, to exclude coverage for some or all contraceptive services under the base medical and prescription drug plan that such nonprofit religious organization provides, purchases or arranges for Covered Persons from or through the Claims Administrator.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Explanation of Benefits (EOB) – a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- any other reductions taken;
- the net amount paid by the Claims Administrator; and
- the reason(s) why the service or supply was not covered.

Hospital – an institution, operated as required by law, which:

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

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

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

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – healthcare services provided for the purpose of preventing conception, preventing, evaluating, diagnosing or treating a Sickness, Injury, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, disease or its symptoms, or for preventing conception;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to prevent conception or produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available,

observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your Contraceptive Services Only ID card, and to Physicians and other health care professionals on UnitedHealthcare Online.

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

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

Participant – a participant of a base medical and prescription drug plan provided by an Eligible Organization who meets the eligibility requirements described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

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

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

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this Booklet does not include mental illness or substance use disorder, regardless of the cause or origin of the mental illness or substance use disorder.

Spouse – an individual to whom you are legally married.

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

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

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. The Claims Administrator issues, from time to time, medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

SECTION 12 - PREVENTIVE CARE MEDICATIONS

What this section includes:

- Benefits available for Preventive Care Medications prescribed to prevent conception;
- How to utilize the retail and mail order service for obtaining Preventive Care Medications;
- Definitions of terms used throughout this section relate to the Preventive Care Medication Benefits for Contraceptives.

Retail

The Contraceptive Services Only Benefit has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting the Claims Administrator at the toll-free number on your Contraceptive Services Only ID card or by logging onto www.myuhc.com.

To obtain your prescription from a Network Pharmacy, simply present your Contraceptive Services Only ID card. The Contraceptive Services Only Benefit pays Benefits for certain covered Preventive Care Medications:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits; and
- up to three cycles supply of an oral contraceptive at one time.

If you purchase a Preventive Care Medication from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Contraceptive Services Only Benefit.

Note: Preventive Care Medication Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach the Claims Administrator toll-free at the number on your Contraceptive Services Only ID card.

The Plan pays mail order Benefits for certain covered Preventive Care Medications:

- as written by a Physician; and

- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Preventive Care Medication order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Benefits for Preventive Care Medications

Benefits under the Preventive Care Medication Benefits include those Preventive Care Medications as defined under *Glossary – Preventive Care Medications*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the telephone number on your Contraceptive Services Only ID card.

Designated Pharmacy

If you require certain Preventive Care Medications, the Claims Administrator may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Preventive Care Medications.

Please see the Glossary in this section for definition of Designated Pharmacy.

Preventive Care Medications List

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes the final approval of contraceptives' placement on the Preventive Care Medications list. In its evaluation of each Preventive Care Medication, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Preventive Care Medication; and
- available rebates and assessments on the cost effectiveness of the Preventive Care Medication.

When considering a contraceptive for placement on the Preventive Care Medication list, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Preventive Care Medication is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the Preventive Care Medication list. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Preventive Care Medications Benefit Claims

For Preventive Care Medication claims procedures, please refer to Section 6, *Claims Procedures*.

Supply Limits

Some Preventive Care Medications are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Preventive Care Medication has been assigned a maximum quantity level for dispensing, either visit www.myuhc.com or call the toll-free number on your Contraceptive Services Only ID card. Whether or not a Preventive Care Medication has a supply limit is subject to the Claims Administrator's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator have developed, subject to 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.

Rebates and Other Discounts

The Claims Administrator may, at times, receive rebates for certain drugs on the Preventive Care Medication list. The Claims Administrator does not pass these rebates and other discounts on to you.

The Claims Administrator and a number of its affiliated entities conduct business with various pharmaceutical manufacturers separate and apart from this Preventive Care Medication section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Preventive Care Medication section. The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

Glossary – Preventive Care Medications

Designated Pharmacy – a pharmacy that has entered into an agreement with the Claims Administrator or an organization contracting on [Legal Entity Variable]'s behalf, to provide specific Preventive Care Medications. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Preventive Care Medications to Covered Persons;
- agreed to accept specified reimbursement rates for Preventive Care Medications; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, placing contraceptives on the Preventive Care Medications list.

Preventive Care Medications – a medication, product or device that prevents conception, including but not limited to, oral contraceptives and diaphragms, that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Preventive Care Medication includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. A Preventive Care Medication also includes an over-the-counter medication the Claims Administrator designates as eligible for coverage as a Preventive Care Medication as if it were a prescription drug if it is prescribed by a Physician. Preventive Care Medications must be obtained at a Network Pharmacy and only include those that are required to be covered by the federal Patient Protection and Affordable Care Act pursuant to the comprehensive guidelines for women supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling the Claims Administrator at the toll-free telephone number on your Contraceptive Services Only ID card.

SECTION 13 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Contraceptive Services Only Benefit administrative information.

This section includes information on the administration of the Contraceptive Services Only Benefit. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Coverage Description

Claims Administrator: The company which provides certain administrative services for the Benefits described in this Booklet.

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Contraceptive Services Only Benefit. The Agent of Service is:

Agent for Legal Process –Contraceptive Services Only Benefit.
United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

If your claim for a Contraceptive Services Only benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 6, *Claims Procedures*, for details.

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Contraceptive Services Only Benefit. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Contraceptive Services Only Benefit.

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