

Off-Marketplace ACA Plans

Health insurance for individuals and families



These Off-Marketplace plans offer Minimum Essential Coverage but are not ACA tax credit eligible.

UnitedHealthcare Life Insurance Company (UHCLIC) is the underwriter and administrator of these plans offered Off-Exchange.

Policy Forms OFX16-P: -BCS1-45, -BCS2-45, -SCS1-45, -SCS2-45, -SCS3-45, -GCS-45, -BHSA-45, -SHSA-45, -SS-45

 **UnitedHealthcare®**
UnitedHealthcare Life
Insurance Company



Why choose us?

29
MILLION

UnitedHealthcare provides nearly 29 million Americans access to health care. UnitedHealthcare Life Insurance Company (UHCLIC), a UnitedHealthcare company, is the underwriter and administrator of the plans featured in this brochure. Source: UnitedHealth Group Annual Form 10-K for year ended 12/31/14.

“A”

UnitedHealthcare Life Insurance Company is rated “A” (Excellent) by A.M. Best. This worldwide independent organization examines insurance companies and other businesses, and publishes its opinion about them. This rating is an indication of our financial strength and stability. (12-11-14)

94%

94% of all health claims are processed within 12 working days or less. Our employees who process claims have a long history of outstanding claims service. Source: Actual 2014 results.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy.

This insurance coverage is not designed or marketed as employer-provided insurance. It does not comply with Virginia small-employer group health insurance laws. These plans cannot be used, now or in the future, by you or an employer to provide insurance for employees.



How our plans work

All of our plans use a network of doctors, hospitals, and other providers that offer you quality health care. You get the most value when you use network providers.

Visit UHOne.com and select [Find A Doctor](#) under Customer Center to search for UnitedHealthcare Choice Plus network providers.

UnitedHealthcare Choice Plus network

- 1 Use any doctor in the Choice Plus network.** No Primary Care Physician (PCP) required.
- 2 See any network specialist without needing a referral.**
- 3 Use network physicians and facilities** to get the highest level of benefits from your plan. Using non-network providers will cost you more. See Non-Network Penalty on page 15.
- 4 Call for Prior Authorization for certain services and supplies.** See Prior Authorization on page 16 for a listing. The notification phone number is on your ID card. Additional details below.



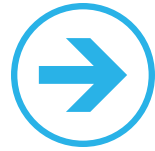
UnitedHealthcare Choice Plus network

This is an “open access” network of doctors, hospitals, and other providers. You have the freedom to choose your Choice Plus network physician or specialist anywhere within the U.S.; a referral is not required. Getting non-emergency care from a doctor or hospital not in our network will cost you more.



Prior Authorization

Prior Authorization is required for certain covered expenses. Without Prior Authorization, benefits are reduced by 20%. Prior Authorization does not guarantee payment. Read your policy carefully for details.



Copay Plans

Do you have frequent doctor visits and/or take Rx drugs for routine care?



Convenient Doctor Office Copays

A predictable copay may help you manage your budget. You pay a set amount for your doctor visits* without needing to meet the deductible first.



Prescription Drug Coverage

Most plans offer a tiered copay for name brand and generic prescriptions. Check tier status for a prescription drug by visiting UHOne.com/Rx-drugs or by calling the telephone number on your ID card. Tier 1 contraceptives are covered under preventive care at no cost.



Pediatric Dental/Pediatric Vision

For covered persons under the age of 19. Subject to the deductible and coinsurance (if applicable). Exclusions and limitations apply, as defined in the policy.

The chart summarizes standard covered expenses using network providers. Prior Authorization is required for certain services and some Rx drugs. For more information, including General Exclusions and Limitations, see pages 11-16.

* Some plans have a limited number of doctor visits at the copay amount. See the chart for details.

View a sample policy at: UHOne.com/sample-policy

Highlights of network covered expenses

| | | Bronze Copay Select SM | | Silver Copay Select SM | | | Gold Copay Select SM | |
|--|----------|---|---|---|---|---|---|--|
| | | 1 | 2 | 1 | 2 | 3 | | |
| Network | | UnitedHealthcare Choice Plus | | | | | | |
| Deductible (per calendar year, excludes all copays) | You pay: | \$5,000 per person | \$6,000 per person | \$5,000 per person | \$2,500 per person | \$3,500 per person | \$1,000 per person | |
| Coinsurance (% you pay after deductible, per calendar year) | You pay: | 30% per person | 30% per person | 20% per person | 30% per person | 20% per person | 20% per person | |
| Out-of-Pocket Maximum (includes all copays, deductibles, and coinsurance) | You pay: | \$6,850 per person, \$13,700 per family | \$6,850 per person, \$13,700 per family | \$6,100 per person, \$12,200 per family | \$6,850 per person, \$13,700 per family | \$6,200 per person, \$12,400 per family | \$6,850 per person, \$13,700 per family | |

Doctor Office

| | | UnitedHealthcare Choice Plus | | | | | |
|--|----------|---|----------------------|----------------------|---|----------------------|---------------------------------------|
| Primary Care Physician (PCP) / Specialist | | You select any network physician. No referral required to see a specialist. | | | | | |
| Preventive Care See page 11 for details. | You pay: | No charge — 100% covered in-network. | | | | | |
| Office Visit, History, and Exam only - Primary (deductible does not apply) | You pay: | \$50 copay-2 visit limit ^{1,2} | \$50 copay | \$20 copay | \$35 copay-4 visit limit ^{1,2} | \$20 copay | \$25 copay |
| Office Visit, History, and Exam only - Specialist (deductible does not apply) | You pay: | \$150 copay | \$150 copay | \$40 copay | \$70 copay | \$40 copay | \$30 copay |
| Urgent Care Center | You pay: | 30% after deductible | 30% after deductible | 20% after deductible | 30% after deductible | 20% after deductible | \$50 copay-2 visit limit ² |

¹ Includes Outpatient Mental Health visits.

² Per covered person, per calendar year. Additional visits subject to deductible and coinsurance.

Pharmacy

| Name Brand and Generic Prescription (Rx) Drugs | Rx Deductible | You pay: | Medical deductible applies | Tiers 3-4 combined: \$750 per person | Tiers 3-4 combined: \$750 per person | Tiers 3-4 combined: \$500 per person | Tiers 3-4 combined: \$500 per person | Tiers 3-4 combined: \$500 per person |
|--|---|---|---|---|--------------------------------------|---|--------------------------------------|--------------------------------------|
| | Each prescription/refill limited to a 34-day supply. If you purchase name-brand prescription when generic is available, you pay your copay plus the additional cost above the generic price. Generic drugs may be found in any tier. ³ Deductible does not apply. | Tier 1 | You pay: | 30% after deductible, Preferred Price Card: You pay for Rx drugs at the point of sale, at the lowest price available, and submit a claim to us. | \$20 copay ³ | | \$10 copay ³ | |
| Tier 2 | You pay: | \$50 copay ³ | | | \$40 copay ³ | | \$35 copay ³ | |
| Tier 3 | You pay: | After Rx deductible, the greater of: \$150 or 20% coinsurance | After Rx deductible, the greater of: \$150 or 20% coinsurance | | | After Rx deductible, the greater of: \$135 or 20% coinsurance | | |
| Tier 4 | You pay: | After Rx deductible, the greater of: \$300 or 30% coinsurance | After Rx deductible, the greater of: \$300 or 30% coinsurance | | | After Rx deductible, the greater of: \$285 or 30% coinsurance | | |

Outpatient

| | | | | | | | |
|---|----------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Emergency Room Fees (additional \$250 ER deductible for illness if not admitted) | | | | | | | |
| X-ray and Lab | You pay: | 30% after deductible | 30% after deductible | 20% after deductible | 30% after deductible | 20% after deductible | 20% after deductible |
| Facility/Hospital for Outpatient Surgery | | | | | | | |

Inpatient

| | | | | | | | |
|---|----------|----------------------|--|----------------------|----------------------|----------------------|----------------------|
| Hospital Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Rx Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses | You pay: | 30% after deductible | \$500 copay per admit, then 30% after deductible | 20% after deductible | 30% after deductible | 20% after deductible | 20% after deductible |
|---|----------|----------------------|--|----------------------|----------------------|----------------------|----------------------|

Pregnancy/Maternity Care

| | | | | | | | |
|---|----------|--------------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Prenatal Care | You pay: | No charge — 100% covered in-network. | | | | | |
| Delivery, Inpatient Services, and Postnatal Care | You pay: | 30% after deductible | 30% after deductible | 20% after deductible | 30% after deductible | 20% after deductible | 20% after deductible |

Mental Health Disorders (including substance abuse)

| | | | | | | | |
|--|----------|---|--|----------------------|---|----------------------|----------------------|
| Outpatient Office Visit, History, and Exam only (deductible does not apply) | You pay: | \$50 copay - part of 2 office visit limit above | \$50 copay | \$20 copay | \$35 copay - part of 4 office visit limit above | \$20 copay | \$25 copay |
| Inpatient Services | You pay: | 30% after deductible | \$500 copay per admit, then 30% after deductible | 20% after deductible | 30% after deductible | 20% after deductible | 20% after deductible |



HSA Plans

Do you rarely see a doctor? Would you be OK with a higher deductible? HSA plans offer health insurance with an advantage—an optional tax-deferred savings account that can be used to pay eligible out-of-pocket expenses.



Insurance with a Simple Design

You meet your deductible, then the plan pays 100% of covered expenses for the calendar year.



Health Savings Account (Optional)

Use the dollars you save tax free for qualified health care expenses, including your insurance deductible. Your savings are tax deductible from gross income up to the IRS limit.



Pediatric Dental/Pediatric Vision

For covered persons under the age of 19. Subject to the deductible and coinsurance (if applicable). Exclusions and limitations apply, as defined in the policy.

The chart summarizes standard covered expenses using network providers. Prior Authorization is required for certain services and some Rx drugs. For more information, including General Exclusions and Limitations, see pages 11-16.

Health Savings Account Details

The account holder for the optional savings account must: (1) be the primary insured for an HSA 100® plan; (2) not be enrolled in Medicare; and (3) not be a dependent on another person's tax return.

We have chosen Optum BankSM, Member FDIC, a leading custodian of health savings accounts, as our recommended financial institution.

Optum BankSM will service your account and send information directly to you about your HSA.

This is only a brief summary of the applicable federal law. Consult your tax advisor for more details of the law. Any fees associated with your account will be provided with your Optum BankSM Welcome Kit.

If you prefer, you can purchase the qualified health insurance plan from us and set up your savings account with another qualified custodian.

View a sample policy at: UHOne.com/sample-policy

Highlights of network covered expenses

| | | Bronze HSA 100® | Silver HSA 100® |
|---|----------|--|---|
| Network | | UnitedHealthcare Choice Plus | |
| Deductible (per calendar year) | You pay: | \$6,500 per person, \$13,000 per family | \$4,000 per person, \$8,000 per family |
| Coinsurance (% you pay after deductible, per calendar year) | You pay: | 0% | 0% |
| Out-of-Pocket Maximum (includes deductible) | You pay: | \$6,500 per covered person, \$13,000 per family | \$4,000 per covered person, \$8,000 per family |
| Maximum 2016 HSA Contribution (IRS Limits) | | \$3,350 per person (over age 55 additional \$1,000 catch-up contribution), \$6,750 per family | |

Doctor Office

| | | | |
|--|----------|---|--|
| Primary Care Physician (PCP) / Specialist | | You select any network physician. No referral required to see a specialist. | |
| Preventive Care See page 11 for details. | You pay: | No charge — 100% covered in-network. | |
| Office Visit, History, and Exam only - Primary | You pay: | No charge after deductible | |
| Office Visit, History, and Exam only - Specialist | | | |
| Urgent Care Center | | | |

Pharmacy

| | | | | |
|---|----------------------|----------|--|--|
| Name Brand and Generic Prescription (Rx) Drugs Each prescription/refill limited to a 34-day supply. | Rx Deductible | You pay: | Medical deductible applies | |
| | Tier 1 | You pay: | No charge after deductible — Preferred Price Card: You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us. | |
| | Tier 2 | | | |
| | Tier 3 | | | |
| | Tier 4 | | | |

Outpatient

| | | | |
|---|----------|----------------------------|--|
| Emergency Room Fees | You pay: | No charge after deductible | |
| X-ray and Lab | | | |
| Facility/Hospital for Outpatient Surgery | | | |

Inpatient

| | | | |
|---|----------|----------------------------|--|
| Hospital Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Rx Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses | You pay: | No charge after deductible | |
|---|----------|----------------------------|--|

Pregnancy/Maternity Care

| | | | |
|---|----------|--------------------------------------|--|
| Prenatal Care | You pay: | No charge — 100% covered in-network. | |
| Delivery, Inpatient Services, and Postnatal Care | You pay: | No charge after deductible | |

Mental Health Disorders (including substance abuse)

| | | | |
|--|----------|----------------------------|--|
| Outpatient Office Visit, History, and Exam only | You pay: | No charge after deductible | |
| Inpatient Services | | | |



Catastrophic Plan

Designed to help people under 30 or those with hardship exemptions.



Two Ways to Qualify:

1. Be under age 30.

You may continue this plan as Minimum Essential Coverage (MEC) until the end of the year during which you turn age 30.

OR

2. Receive a “Certificate of Exemption.”

If you cannot afford Minimum Essential Coverage or you are eligible for a hardship exemption, apply for a Certificate of Exemption from the Federal Marketplace.

Important note: If you are age 30 or over and do not receive a “Certificate of Exemption” from the Federal Marketplace, the Select SaverSM plan will not serve as Minimum Essential Coverage and you may be subject to a tax penalty.



Our lowest premiums

Three primary care doctor office visits (per covered person, per calendar year) for history and exam with a \$35 copay. You meet your deductible, then the plan pays 100% of covered expenses for the calendar year.



Pediatric Dental/Pediatric Vision

For covered persons under the age of 19. Subject to the deductible and coinsurance (if applicable). Exclusions and limitations apply, as defined in the policy.

The chart summarizes standard covered expenses using network providers. Prior Authorization is required for certain services and some Rx drugs. For more information, including General Exclusions and Limitations, see pages 11-16.

View a sample policy at: UHOne.com/sample-policy

Highlights of network covered expenses

Select SaverSM (Catastrophic Plan)

| Network | UnitedHealthcare Choice Plus | |
|---|------------------------------|--|
| Deductible (per calendar year, excludes all copays) | You pay: | \$6,850 per person |
| Coinsurance (% you pay after deductible, per calendar year) | You pay: | 0% |
| Out-of-Pocket Maximum (includes all copays and deductible) | You pay: | \$6,850 per covered person, \$13,700 per family |

Doctor Office

| | | |
|--|----------|---|
| Primary Care Physician (PCP) / Specialist | | You select any network physician. No referral required to see a specialist. |
| Preventive Care See page 11 for details. | You pay: | No charge — 100% covered in-network. |
| Office Visit, History, and Exam only - Primary | You pay: | \$35 copay — 3 visit limit.* |
| Office Visit, History, and Exam only - Specialist | You pay: | No charge after deductible |
| Urgent Care Center | | |

* Per covered person, per calendar year. Additional visits subject to deductible.

Pharmacy

| | | | |
|---|----------------------|----------|---|
| Name Brand and Generic Prescription (Rx) Drugs Each prescription/refill limited to a 34-day supply. | Rx Deductible | You pay: | Medical deductible applies |
| | Tier 1 | You pay: | No charge after deductible — Preferred Price Card: You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us. |
| | Tier 2 | | |
| | Tier 3 | | |
| | Tier 4 | | |

Outpatient

| | | |
|---|----------|----------------------------|
| Emergency Room Fees | You pay: | No charge after deductible |
| X-ray and Lab | | |
| Facility/Hospital for Outpatient Surgery | | |

Inpatient

| | | |
|---|----------|----------------------------|
| Hospital Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Rx Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses | You pay: | No charge after deductible |
|---|----------|----------------------------|

Pregnancy/Maternity Care

| | | |
|---|----------|--------------------------------------|
| Prenatal Care | You pay: | No charge — 100% covered in-network. |
| Delivery, Inpatient Services, and Postnatal Care | You pay: | No charge after deductible |

Mental Health Disorders (including substance abuse)

| | | |
|--|----------|----------------------------|
| Outpatient Office Visit, History, and Exam only | You pay: | No charge after deductible |
| Inpatient Services | | |



Glossary

Note: These definitions are provided only to give you a general understanding of how these words are sometimes used by health insurance companies. Please refer to your coverage documents for a complete list of defined terms that apply to your specific coverage.

benefit - A service or supply that is covered under a health insurance plan. This might include office visits, lab tests, and procedures during the course of treatment.

coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the eligible expense for the service. You pay coinsurance after you pay your deductible.

complications of pregnancy - Severe conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the baby. Morning sickness and elective cesarean section are not complications of pregnancy.

copay/copayment - A fixed amount (for example, \$35) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

deductible - The amount of money you owe for health care services your health insurance covers before your health insurance or plan begins to pay.

eligible expenses - Maximum amount on which payment is based for covered health care services. This may also be called “allowed amount,” “payment allowance,” “negotiated rate,” or “covered expense.”

emergency services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

excluded services - Health care services that your health insurance doesn't pay for or cover.

limitation - The most, in terms of cost and services, a health plan will cover.

minimum essential coverage - The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act (ACA).

network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

network provider - A provider who has a contract with your health plan's network to provide services to you at a discount.

non-network provider - A provider who doesn't have a contract with your health plan's network. You'll pay more to see an out-of-network provider for non-emergency services. This may also be called an “out-of-network provider.”

premium - The amount that must be paid for your health insurance. You usually pay it monthly or quarterly.

prescriptions/Rx drugs - Drugs and medications that by law require a prescription.

urgent care center - A facility, not including a hospital emergency room or doctor's office, that provides treatment or services that are required: (a) to prevent serious deterioration of a covered person's health; and (b) as a result of an unforeseen illness, injury, or the onset of acute severe symptoms.



Preventive care services are covered at no charge to you when using a network provider.

Preventive Care Benefits

Preventive services are intended to prevent disease or to identify disease while it is more easily treatable. A preventive service is provided for someone who does not have symptoms. The following are some examples of covered preventive care services depending on age, gender, family history, and other risk factors. Please note, however, these may change as government recommendations and guidelines change.

Preventive Benefits for All Covered Persons:

- Annual wellness visits.
- Standard immunizations recommended by the ACIP.
- Screening and counseling in a primary care setting for alcohol or substance abuse, tobacco use, obesity, and diet and nutrition.
- Specific screenings (e.g., PSA (men only), colorectal cancer, elevated cholesterol, lipids, sexually transmitted diseases, HIV, high blood pressure, diabetes, and depression).

Preventive Benefits for Children:

- Fluoride treatments.
- Screening for major depressive disorders.
- Standard metabolic screening panel for inherited enzyme deficiency diseases.
- Screening for newborns (e.g., hearing, thyroid, phenylketonuria, and sickle cell anemia).
- Counseling for obesity.
- Specific screenings (e.g., vision, developmental, autism, lead, and tuberculosis).

Preventive Benefits for Women:

- Breastfeeding support, supplies, and counseling.
- Evaluation and testing for breast cancer BRCA gene.
- Counseling women at high risk of breast cancer for chemoprevention.
- Contraceptive services.
- Some contraceptive prescriptions are covered under preventive at no cost. Copay plans limited to Tier 1 only.
- Screening and counseling for HIV.
- Human papillomavirus DNA Testing.
- Screening and counseling for interpersonal and domestic violence.
- Some prenatal care.
- Counseling for sexually transmitted infections.
- Specific screenings (e.g., mammography, cervical cancer including pap smears, gonorrhea, chlamydia, syphilis screenings, and osteoporosis screening).

Important note: Once a covered person exhibits symptoms that require further testing or diagnosis, those services are no longer considered to be preventive care and are subject to the deductible and any applicable copay or coinsurance.



Medical Benefits (all plans)

Subject to all policy provisions, the deductible, and any applicable copay or coinsurance, the following medical benefits are provided. You will find complete coverage details in the sample policy at UHOne.com/sample-policy.

Ambulance Services – Emergency

Dental Services – Accidental Injury

Diagnostic Services

Durable Medical Equipment

Emergency Care

Habilitative Services

Home Health Services

Hospice Services

Hospital Charges

**Medical Devices, Prosthetics,
and Appliances**

**Mental/Behavioral Health Services and
Substance Abuse Disorders**

Pediatric Dental/Pediatric Vision

Pregnancy Expenses

Prescription Drugs

Preventive Care

**Rehabilitation Facility/Skilled Nursing
Facility Expenses**

**Spinal Manipulation/Manual Medical
Interventions**

Temporomandibular Joint Disorder (TMJ)

Therapy Services

Transplants

Walk-In Clinic

Exclusions and limitations may apply. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are subject to eligible expense limits unless you use a network provider. This is only a general outline. It is not an insurance contract, nor part of the insurance policy.



What's not covered (all plans)

This is only a general outline of the coverage provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy.

General Exclusions

Benefits will not be paid for services or supplies that are not administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy.

No benefits are payable for expenses:

- That would not have been charged if you did not have insurance.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the policy or are in excess of the eligible expenses. You are responsible for payment of services not covered by the policy.
- For services or supplies that are provided prior to the effective date or after the termination date of the policy.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast augmentation or reduction, unless medically necessary.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- For drugs, treatment, or procedures promoting conception, including, but not limited to, artificial insemination or treatment of infertility or impotency. (This exclusion does not apply to the treatment of any underlying medical condition resulting in infertility.)
- For drugs that prevent childbirth by causing a conceived pregnancy to terminate (unless the life of the mother is endangered by a physical disorder, physical illness or injury, including life-endangering physical condition caused by or arising from the pregnancy itself; or when the pregnancy is the result of an alleged act of rape or incest).
- For male sterilization or reversals of sterilization.
- For fetal reduction surgery (unless medically necessary).
- For abortion (unless the life of the mother is endangered by a physical disorder, physical illness or injury, including life-endangering physical condition caused by or arising from the pregnancy itself; or when the pregnancy is the result of an alleged act of rape or incest).
- For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as provided for in the policy.
- For telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For a hospital admission on Friday or Saturday (room, board, and nursing services), unless it is an emergency or medically necessary surgery is scheduled on the next day.
- For standby availability of a medical practitioner when no treatment is rendered.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment. (Cosmetic treatment does not include reconstructive surgery which is incidental to or follows surgery resulting from trauma, infection, or disease of the involved part or reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect.)
- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems, except as provided in the policy.
- Resulting from nicotine addiction (except as provided for in the policy).
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplants in the policy.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism
- While confined primarily to receive custodial care, except for hospice care.



What's not covered, continued (all plans)

General Exclusions, continued

No benefits are payable for expenses:

- For educational, vocational or self-management training services, except as otherwise specifically covered or when received as part of a covered wellness visit or screening.
- For alternative or complementary medicine using non-orthodox practices that do not follow conventional medicine, including but not limited to: wilderness or outdoor therapy, boot camp, and equine therapy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy.
- For premarital examinations.
- For or resulting from experimental or investigational treatments, or unproven services, except as provided for in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. Should a workers' compensation insurance carrier deny coverage for a covered person's claim, this exclusion will still apply unless the denial is appealed to and upheld by the proper government agency.
- Resulting from: illness or injury caused by a declared or undeclared act of war; or participation in a riot or felony.
- While under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For or related to surrogate parenting.
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- For routine foot care, treatment of flat feet or subluxation, shoes, shoe orthotics, shoe inserts, and arch supports, except as provided for in the policy.
- For tuition or for services that are school-based.
- For prescription drugs to enhance sexual performance, or to treat impotency or for prescription drugs prescribed due to addiction to, or dependency on, food.

General Limitations

- When using a network physician or facility, non-covered expenses may not be eligible for a network provider discount.
- All covered expenses are subject to applicable limitations set forth in the policy.



Other Details (all plans)

Conditions Prior to Legal Action

The policy includes a provision to help resolve legal disputes. It requires that you provide us written notice of intent to sue before taking legal action. Your notice must identify the source of the disagreement and include all facts and information supporting your position. An action for punitive damages (or other damages not spelled out in the contract) is waived if the claims at issue or disagreement are resolved or corrected within 30 days of written notice, unless prohibited by law.

Continuing Eligibility Requirements

A covered person's eligibility will end on the date:

- A covered person no longer lives, works, or resides in the **network service area** where the policy was issued; or
- That a covered person accepts any direct or indirect contribution or reimbursement by or on behalf of any health care provider or any health care provider sponsored organization for any portion of the premium for coverage under the policy.

“Network service area” means the entire state of Virginia.

If the primary insured moves out of the network service area, he or she may designate another covered person as the new primary insured who remains in the network service area. Covered persons who meet the definition of “dependent” for the new primary insured may remain covered under the policy.

A covered spouse will no longer be covered by this plan at the end of the premium period in which he or she is no longer your dependent due to divorce. A covered child will no longer be covered by this plan at the end of the calendar year in which he or she is no longer an eligible child.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. “Spouse” means the person to whom you are legally married. “Eligible child” means your or your spouse's child, if that child is less than 26 years of age.

A “child” may be: (A) a natural child; (B) a legally adopted child; (C) a child placed with you for adoption; or (D) a child for whom legal guardianship has been awarded to you or your spouse.

Eligible Expense

An eligible expense means a covered expense as follows:

- **For Network Providers:** The contracted fee for the provider.
- **For Non-Network Providers:** As defined in the policy.

Emergency

A medical condition with acute symptoms that are severe enough (including severe pain) that a prudent person, with average knowledge of health and medicine, could reasonably expect that without immediate medical attention: the health of the covered person (if pregnant, the health of the mother or unborn child) would be in serious jeopardy; bodily functions would be seriously impaired; or serious dysfunction of a body part or organ would result.

Non-Network Penalty

For non-emergency care received from Non-Network Providers you pay: (a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible (this does not apply to pediatric dental); and (c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.



Other Details, continued (all plans)

Premium

You are responsible for your premium. Payment must be made directly to our office. We may change the premium rates on January 1 of each calendar year. We will give you at least 75 days notice prior to the date of the change. Some of the factors used in determining your premium rates are the policy plan, tobacco use status, type and level of benefits, place of residence on the premium due date, and age of covered persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

Prior Authorization Required

You must call us before receiving certain services as listed below. Without Prior Authorization, benefits will be reduced by 20% (and pediatric orthodontic services may be denied). Prior Authorization does not guarantee payment. You must call during the time frame specified in the policy. The time frame varies by service or supply.

You must call us before receiving these services:

- Ambulance, non-emergency.
- Clinical Trials.
- Dental Services (post-emergency treatment of an injury).
- Pediatric Orthodontic Services (claim may be denied if you do not call).
- Transplants.

You must call us before receiving these services and supplies from a **NON-NETWORK** provider:

- Autism Spectrum Disorder Services.
- Diabetes Equipment – exceeding \$1000.
- Durable Medical Equipment – exceeding \$1000.
- Home Health Care.
- Inpatient Hospice Care.
- Inpatient Hospital Stay.
- Lab, X-ray, and Major Diagnostics (includes CT, PET, MRI, MRA, and Nuclear Medicine).

- Mental Health Services.
- Outpatient Surgery.
- Pregnancy and Delivery Services.
- Reconstructive Surgery.
- Rehabilitation and Extended Care Facility Services.
- Substance Abuse Disorder Services.
- Temporomandibular Joint (TMJ) Services.
- Therapeutic Treatments: Dialysis and certain radiation and ultrasound treatments.

Certain outpatient prescription drugs require Prior Authorization. Your doctor's office, pharmacist, or you should call us. Without Prior Authorization, benefits will be reduced or denied.

Renewability/Termination

You may renew your coverage by paying the premium as it comes due. We may refuse to renew if: (a) you fail to pay the premium; (b) we do not renew all policies just like yours for everyone in the state where you then live; or (c) there is fraud or an intentional material misrepresentation made by or with knowledge of a covered person in the filing of a claim for benefits.

HEALTH PLAN NOTICES OF INFORMATION PRACTICES
MEDICAL INFORMATION PRIVACY NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. (Effective January 1, 2015)

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as www.myuhone.com, www.myallsavers.com, www.myallsaversmember.com, or www.goldenrule.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information. We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special restrictions apply regarding when we may disclose health information to family members and others involved in a deceased individual’s care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health

information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

What Are Your Rights. The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a PO Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our websites such as www.myuhone.com, www.myallsavers.com, www.myallsaversmember.com, or www.goldenrule.com.

- **You have the right to be considered a protected person.** (New Mexico only) A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice. In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the federal Fair Credit Reporting Act. We may disclose information solely about our transactions or experiences with you to our affiliates.

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members. If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Park Ste. 400, Braintree, MA 02184-8734, (866) 692-6901, www.mib.com.

FINANCIAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2015)

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect. Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

Confidentiality and Security. We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice. If you have any questions about this notice, please **call the toll-free phone number on your ID card.**

The Notice of Information Practices, effective January 1, 2015, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; PacificCare Life and Health Insurance Company; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company.

To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

TO BE COMPLETED BY PRODUCER ONLY IF PERSONALLY COLLECTING INITIAL PREMIUM PAYMENT.

Conditional Receipt for: _____
Proposed Insured: _____
Amount Received: _____

Date of Receipt: _____
Signature of Secretary: *Richard C. Sullivan*
Signature of Agent/Broker: _____

**THIS FORM LIMITS OUR LIABILITY. NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL THREE CONDITIONS PRIOR TO COVERAGE ARE MET.
NO PERSON IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS. YOUR CANCELLED CHECK WILL BE YOUR RECEIPT.**

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided in the Conditions Prior to Coverage.

Conditions Prior to Coverage (Applicable with or without the Conditional Receipt)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by UnitedHealthcare Life Insurance Company.
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date, and any check is honored on first presentation for payment.
3. The policy is: (a) issued by UnitedHealthcare Life Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

A copy of your Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize UnitedHealthcare Life Insurance Company to initiate debit entries to the account indicated below.

I also authorize the named financial institution to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

EFT-UL-1013

Notice to applicant regarding replacement of accident and sickness insurance

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
2. We recommend that you not terminate your present plan until you are certain that your coverage has been approved by UnitedHealthcare Life Insurance Company.

Incorrect or incomplete information on your application may result in voidance of coverage and claim denial. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.

Keep this document. It has important information.

