UnitedHealthcare®

SignatureValue™ Harmony HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits
SignatureValue Harmony HMO Gold 35-70/20%/500 Ded

These services are covered as indicated when authorized through your Primary Care Physician in your Network Participating Medical Group.

General Features

Calendar Year Deductible Covered Services will not be covered until you meet the Calendar Year Deductible. Only amounts incurred for Covered Services that are subject to the Deductible will count toward the Deductible. The Deductible applies to the Annual Out-of-Pocket Limit. The amounts applied to the Deductible are based upon UnitedHealthcare's contracted rates. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$500/Individual $1,000/Family
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including pediatric vision, pediatric dental, behavioral health, prescription drug, chiropractic, and acupuncture benefits. It does not include standalone, separate and independent Dental and Vision benefit plans or infertility benefit, if purchased by the employer group. When an individual member of a family unit satisfies the individual out of pocket limit for the calendar year, no further co-payments will be required for that individual member for the remainder of the calendar year. The remaining family members will continue to pay co-payments until a member satisfies the individual out-of-pocket or the family as a whole meets the family out of pocket limit. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$8,000/Individual $16,000/Family
PCP/Other Practitioner Office Visits	$35 Office Visit Co-payment
Specialist (Member required to obtain referral to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$70 Office Visit Co-payment
Hospital Benefits	20% Co-payment after Deductible
Emergency Services (Co-payment waived if admitted)	$500 Co-payment after Deductible
Urgently Needed Services	
Urgent care services – services provided **within** the geographic area served by your medical group	$35 Office Visit Co-payment
Urgent care services – services provided **outside** of the geographic area served by your medical group	$100 Co-payment
Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the geographic area served by your medical group.	

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% Co-payment after Deductible
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payments or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less)	20% Co-payment after Deductible
Hospital Benefits	20% Co-payment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% Co-payment after Deductible
Maternity Care Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as No charge. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan ID card.	20% Co-payment after Deductible
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	20% Co-payment after Deductible
Newborn Care The inpatient hospital benefits Co-payment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.	20% Co-payment after Deductible
Physician Care	20% Co-payment
Reconstructive Surgery	20% Co-payment after Deductible
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	20% Co-payment after Deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	20% Co-payment after Deductible
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	20% Co-payment after Deductible
Termination of Pregnancy (Medical/medication and surgical)	No charge

Benefits Available on an Outpatient Basis

Acupuncture **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$10 Co-payment
Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	$35 Office Visit Co-payment
Specialist	$70 Office Visit Co-payment

Benefits Available on an Outpatient Basis (Continued)

Ambulance (Only one ambulance Co-payment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Co-payment)	$100 Co-payment
Chiropractic Care (20-visit maximum per calendar year) **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$15 Co-payment
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payments or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the member.
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply) Co-payment shall never exceed the plan's actual cost of the service.	$70 Co-payment per item
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply. Please refer to your Dental Supplement to the Combined Evidence of Coverage and Disclosure Form for pediatric dental benefits.)	$50 Co-payment
Depo-Provera Medication – (other than contraception) Limited to one Depo-Provera injection every 90 days. (Additional Co-payment for office visits may apply.)	$75 Co-payment
Dialysis (Physician office visit Co-payment may apply)	$70 Co-payment per treatment
Durable Medical Equipment	$70 Co-payment per item
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children who are covered until at least the end of the month in which Member turns 19 years of age.)	No charge
Hearing Aid - Standard ($2,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years.)	$70 Co-payment
Hearing Aid – Bone- Anchored Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered. Bone anchored hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone-anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits
Hearing Exam PCP Office Visit/Nonphysician Health Care Practitioner Office Visit Specialist	 $35 Office Visit Co-payment $70 Office Visit Co-payment

Benefits Available on an Outpatient Basis (Continued)

Home Health Care Visits Home Health visits up to a maximum of 100 visits per year for services other than rehabilitation or habilitation. Home Health visits for rehabilitation up to a maximum of 100 visits per year. Home Health visits for habilitation up to a maximum of 100 visits per year. For covered rehabilitation and habilitative services other than home health visits, please refer to "Outpatient Habilitative Services and Outpatient Therapy" and "Outpatient Rehabilitation and Outpatient Therapy" in this schedule. For Infusion Therapy, a separate Infusion Therapy Co-payment applies per 30 days.	$35 Co-payment per visit
Home Test Kits for Sexually Transmitted Diseases	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this Schedule of Benefits
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services (If purchased by your employer, please refer to your Infertility Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	Not covered
Infusion Therapy (Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.) Co-payment shall never exceed the plan's actual cost of the service.	$150 Co-payment per medication
Injectable Drugs Co-payment not applicable to injectable immunizations, birth control, Infertility and insulin.	
Outpatient Injectable Medication	$150 Co-payment per medication
Self-Injectable Medication	$150 Co-payment per medication
FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are NOT defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form. Co-payment shall never exceed the plan's actual cost of the service.	
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply)	$40 Co-payment
Maternity Care, Tests and Procedures Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as No charge. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan ID card.	
PCP Office Visit	No charge
Specialist	No charge
Mental Health Services Outpatient Office Visits include:	
Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management	$35 Office Visit Co-payment
All Other Outpatient Treatment include:	
Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing, facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental Disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, and psychiatric observation **(Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**)	No charge

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services	20% Co-payment after Deductible
Outpatient Habilitative Services and Outpatient Therapy	$35 Office Visit Co-payment
Outpatient Prescription Drug Benefit Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details. (Co-payment applies per Prescription Unit or up to 31 days)	
Specialty Prescription Drug Products	
Tier 1	$15 Co-payment
Tier 2	$150 Co-payment
Tier 3	$250 Co-payment
Tier 4	25% Co-payment Up to $250 per script
Prescription Drug Products from a Network Retail Pharmacy	
Tier 1	$15 Co-payment
Tier 2	$50 Co-payment
Tier 3	$100 Co-payment
Tier 4	25% Co-payment Up to $250 per script
Prescription Drug Deductible (Per member per Calendar Year)	$100/individual; $200/family Applies to Tiers 2, 3, and 4 (applies to retail and mail service)
Co-payment Maximum of $250 for up to a 31 day supply of an orally administered anticancer medication regardless of a Prescription Drug Deductible and/or Medical Deductible.	
Outpatient Rehabilitation Services and Outpatient Therapy	$35 Office Visit Co-payment
Outpatient Surgery at a Network Free-Standing Outpatient Surgery Facility	20% Co-payment after Deductible
Outpatient Surgery Physician Care	20% Co-payment
Pediatric Dental Services **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Pediatric Vision Services **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	See your Supplement to the UnitedHealthcare of California for pediatric vision benefits.
Physician Care	
PCP Office Visit/Nonphysician Health Care Practitioner Office Visit	$35 Office Visit Co-payment
Specialist	$70 Office Visit Co-payment

Benefits Available on an Outpatient Basis (Continued)

Preventive Care Services Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an “A” or “B” recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group. Covered Health Care Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent care • Well-Woman, including routine prenatal obstetrical office visits • Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card. FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are NOT defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	No charge
Prosthetics and Corrective Appliances Co-payment shall never exceed the plan’s actual cost of the service.	$70 Co-payment per item
Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Co-payment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Co-payment amount if any)	 No charge $300 Co-payment
Radiology Services Standard: (Additional Co-payment for office visits may apply) Specialized Scanning and Imaging Procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure. Co-payment shall never exceed the plan’s actual cost of the service.	 $40 Co-payment $300 Co-payment
Specialized Footwear for Foot Disfigurement Co-payment shall never exceed the plan’s actual cost of the service.	$70 Co-payment per item

Benefits Available on an Outpatient Basis (Continued)

Substance Related and Addictive Disorder Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management All Other Outpatient Treatment includes, but are not limited to: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$35 Office Visit Co-payment No charge
Termination of Pregnancy (Medical/medication and surgical) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are NOT defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	No charge
Vasectomy	$50 Co-payment
Virtual Care Services Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	No charge
Vision Refractions (For pediatric vision, please refer to your Vision Services Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	$30 Office Visit Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the UnitedHealthcare negotiated rate.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR NETWORK MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE. A UTILIZATION REVIEW COMMITTEE MAY REVIEW THE REQUEST FOR SERVICES.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the UnitedHealthcare office and your employer's personnel office. UnitedHealthcare's most recent audited financial information is also available upon request

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

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CAL CHOICE Plan Code: 1T8
PRIME Plan Code: CW-YE
Effective 1/1/2023

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

Outpatient Prescription Drug Schedule of Benefits

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 2, Tier 3 and Tier 4 Prescription Drug Products before we begin paying for Prescription Drug Products. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Drug Deductible.	$100 per Covered Person, not to exceed $200 for all Covered Persons in a family.
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	$5,000 per Covered Person.
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Co-payment • The Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment. • A Network Pharmacy's retail price for the Prescription Drug Product. See the Co-payments in the Benefit Information table for amounts. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at **www.myuhc.com** or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs**: We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at **www.myuhc.com** or the telephone number on your ID card. **Variable Co-payment Program:** Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact **www.myuhc.com** or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment and/or Co-insurance. **Prescription Drug Products Prescribed by a Specialist**: You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at **www.myuhc.com** or the telephone number on your ID card. **NOTE**: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at **www.myuhc.com** or the telephone number on your ID card for the most up-to-date tier status. **Coupons**: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

Payment Term And Description	Amounts
Specialty Prescription Drug Products	
The following supply limits apply. As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. We designate certain Network Pharmacies to be Preferred Specialty Network Pharmacies. We may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to you unless required by law. You may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy by contacting us at **www.myuhc.com** or by the telephone number on your ID card.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at **www.myuhc.com** or the telephone number on your ID card to find out tier placement. *Preferred Specialty Network Pharmacy* For a Tier 1 Specialty Prescription Drug Product: $15 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $150 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $250 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: 25% per Prescription Order or Refill. Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 9: Defined Terms,* for the definition of a High Deductible Health Plan. In addition, a $250 Cap applies to any prescription drug (other than oral cancer). If there is a Deductible, the Cap applies once it is met and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met.
Prescription Drug Products from a Network Retail Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. **You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.** **A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives**.	For a Tier 1 Prescription Drug Product: $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $100 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% per Prescription Order or Refill. Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer

Payment Term And Description	Amounts
When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.	medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 10. Definitions*, for the definition of a High Deductible Health Plan. In addition, a $250 Cap applies to any prescription drug (other than oral cancer). If there is a Deductible, the Cap applies once it is met and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. **All cost sharing applies to the out-of-pocket limit**.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits as written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. You may be required to fill the first Prescription Drug Product order at a retail pharmacy and obtain 2 refills at a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-payment for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	For up to a 90-day supply or Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $100 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $200 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% per Prescription Order or Refill. Co-payment maximum of $250 (“Cap”) for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 10. Definitions*, for the definition of a High Deductible Health Plan. In addition, a $500 Cap applies to any prescription drug (other than oral cancer). If there is a Deductible, the Cap applies once it is met and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met.

This *Schedule of Benefits* provides specific details about your Prescription Drug Product benefit, as well as the exclusions and limitations. Together this document and the *Supplement to the Combined Evidence of Coverage and Disclosure Form* as well as the medical *Combined Evidence of Coverage and Disclosure Form* determine the exact terms and conditions of your Prescription Drug Product coverage.

What Do I Pay When I fill a Prescription?

You have an Annual Drug Deductible $100 per member and $200 per family for covered medications consisting of Tier 2, Tier 3, and Tier 4. This deductible applies to retail and mail order Prescription Drug Products. Except for oral anticancer medications as specified above, until you satisfy the Drug Deductible, you will pay 100 percent of UnitedHealthcare's contracted rate with the Network Pharmacy for the Prescription Drug Product and that amount will be applied towards your Drug Deductible. Only amounts incurred for covered services will apply to the Deductible. The Drug Deductible is calculated on a Calendar Year basis and is not applied towards the Drug Deductible for the following year. Amounts previously applied to your Deductible under a similar prescription drug plan from a different carrier or self-funded benefit plan are not applied to this prescription drug plan.

For Member only coverage, only amounts incurred for covered services will apply toward the Deductible. For the Individual Deductible, if a Member has a $100 Deductible, and the individual purchased a covered outpatient Prescription Drug Product at a Network Pharmacy at the contracted rate of $50, the Individual Deductible is reduced by $50, until the Deductible is satisfied. After the Deductible is satisfied, you will pay only a Co-payment when filling a prescription at a UnitedHealthcare Network Pharmacy.

For family coverage, family members are charged the contracted rate for covered Prescription Drug Products purchased at Network Pharmacies prior to satisfying the Deductible. When individual Members of a family meet the per family Deductible, no further Deductibles are required for Members of the same family. If a Member of the family meets the per person Deductible, no further Deductible is required for that family Member; only a Co-payment applies, but if the family Deductible is not satisfied, the Deductible will apply to other Members of the family. After satisfying the family Deductible, all Members of the family will pay only a Co-payment when filling a prescription at a UnitedHealthcare Network Pharmacy. You will pay a Co-payment every time a prescription is filled.

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

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

For Prescription Drug Products at a Network Retail pharmacy, you will pay the lower of the applicable Co-payment for a Prescription Unit, or the Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from Mail Order**,** you are responsible for paying the lower of either the applicable Co-payment or a Network Pharmacy's retail price for the Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Network Pharmacy. You will pay a Co-payment every time a prescription is filled. Your Co-payments are as shown in the grid above.

NOTE: The Tier status of a prescription drug can change periodically. Tier status changes resulting in higher Co-payments occur six times per calendar year or Contract or Plan Year. We will notify you 60 days prior to the change in tiers that will result in a higher co-payment. Tier changes resulting in lower Co-payments may occur at any time and would be for your benefit. No prior notice would be given to you. When Tier status changes occur, you may pay more or less for a prescription drug depending on the Tier placement. You may access PDL and Specialty Medication, Tier placement and Co-payments by contacting Customer Service Department 1-800-624-8822 or 711 (TTY) or visiting UnitedHealthcare's Web site at **www.myuhc.com.**

You will receive a written notice 60 days prior to an increase in your Co-payment due to the change in Tier placement to move to a higher Tier. The notice will inform you of the new Tier; and if Prior Authorization must be requested by your Network Physician and determined by UnitedHealthcare to be Medically Necessary for the drug to be covered if not previously obtained.

If A Brand-Name Drug Becomes Available as a Generic

If a Generic drug becomes available for a Brand-name drug, your Brand-name drug's Tier placement may change, and therefore your Co-payment may change. Please refer to "PRIOR AUTHORIZATION" if you are currently taking a prescription drug that requires Prior Authorization under the benefit plan.

Prior Authorization

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

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

Certain Prescription Drug Products may be subject to prior authorization due to the following:

- they have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

Prior Authorization and Step Therapy Exception Process

Certain Prescription Drug Products require a Prior Authorization or step therapy exception process using criteria based upon *U.S. Food and Drug (FDA)* approved indications or medical findings. When Prescription Drug Products are dispensed at a Network Pharmacy, your prescribing provider, or the pharmacist, are responsible for obtaining Prior Authorization from us. Please refer to the Outpatient Prescription Drug Benefit Supplement for additional information.

For a list of the Prescription Drug Products that require UnitedHealthcare's Prior Authorization, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**.

Prescription Drug Products Covered by Your Benefit

When prescribed by your Network Physician as Medically Necessary and filled at a Network Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one pre-filled insulin pens**, insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior Authorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs**: Comparable Generic drugs may be substituted for Brand-name drugs. For Brand-name drugs that have *FDA* approved equivalents, a prescription may be filled with a Generic drug unless a specific Brand-name drug is Medically Necessary and Prior Authorized by UnitedHealthcare. Prior Authorization is necessary even if a licensed Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. If you choose to use a Prescription Drug Product not included on the PDL and not Prior Authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication.
- If the requested drug is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your applicable Tier Co-payment.
- **Miscellaneous Prescription Drug Coverage**: For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets and lancet devices, inhaler extender devices, urine test strips, ketone testing strips and tablets, certain immunizations, and anaphylaxis prevention kits. See the medical Combined Evidence of Coverage and Disclosure Form for coverage of other injectable medication and equipment for the treatment of asthma in *Section 5: Your Medical Benefits.*
- **Oral Contraceptives**: All *FDA*-approved contraceptives, drugs, devices, and products are covered at $0 cost sharing subject to Therapeutic Equivalents that may be prescribed and may be subject to Prior Authorization. A Member may receive a 12-month supply of a *FDA*-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a provider or from a contracted pharmacy that has agreed to dispense or furnish *FDA*-approved contraceptives in accordance with state and federal law. Over-the-counter birth control devices require a prescription from your provider. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical Evidence of Coverage and to your Outpatient Prescription Drug Supplement for more information.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most Prescription Drug Products, there are some that are not covered or limited. These Prescription Drugs Products are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section 5: of your medical Combined Evidence of Coverage and Disclosure Form entitled “Exclusions and Limitations" for more information about medications covered by your medical benefit.

- **Administered Prescription Drug Products:** Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber’s staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician’s office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section 5 of your medical Combined Evidence of Coverage and Disclosure Form titled “Covered Health Care Services” for more information about medications covered under your medical benefit.
- **Compounded medication**: Any Medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- **Diagnostic drugs**: Drugs used for diagnostic purposes are not covered. Refer to Section 5 of your medical Combined Evidence of Coverage and Disclosure Form for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional products and food supplements:** Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- **Enhancement medications when prescribed for the following non-medical conditions are not covered:** weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat morbid obesity, mental health and substance use disorders or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer’s dementia.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.
- **Injectable medications**: Except as described under the section “Prescription Drug Products Covered By Your Benefit”, injectable medications including, but not limited to, self-injectables, infusion therapy, allergy serum, certain immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician’s office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare’s Prior Authorization requirements. For additional information, refer to Section 5 of your medical Combined Evidence of Coverage and Disclosure Form under “Your Medical Benefits”.
- **Infertility**: All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section 5 of your medical Combined Evidence of Coverage and Disclosure Form entitled “Your Medical Benefits” for additional information. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Combined Evidence of Coverage under "Covered Health Care Services".
- **Inpatient Prescription Drug Products**: Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to Section 5 of your medical Combined Evidence of Coverage and Disclosure Form entitled “Your Medical Benefits” for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Network Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Network Physician at a Network Pharmacy, and pay the applicable Co-payment on behalf of the Member.

- **Investigational or Experimental drugs**: Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to *California Health and Safety Code Section 1370.4.* Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section 5: Your Medical Benefits and Section 8: Overseeing Your Health Care Decisions.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- **Non-covered medical condition**: Prescription Drug Products for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary Prescription Drug Products directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-label drug use**. Off-label drug use means that the Provider has prescribed a drug approved by the *Food and Drug Administration (FDA)* for a use that is different than that for which the *FDA* approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical Combined Evidence of Coverage and Disclosure Form and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a Network licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) The American Hospital Formulary Service Drug Information, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen; (i) The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics Compendium; (iii) The Thompson Micromedex DRUGDEX System, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a PDL, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Review System as defined in the medical Combined Evidence of Coverage and Disclosure Form.
- **Over-the-Counter Drugs**: Drugs available over-the-counter do not require a Prescription Order or Refill by federal or state law before being dispensed unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
- Prescription Drug Products that are comprised of active ingredients that are available over-the-counter are not covered except when Medically Necessary. Certain prescription drug products that are Therapeutically Equivalent to over the counter drugs or supplement are not covered unless Medically Necessary and Prior Authorized. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit are not covered.
- Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government except as otherwise provided by law.
- Prescription Drug Products prescribed by a dentist or drugs when prescribed for dental treatment are not covered.
- Prescription Drug Products when prescribed solely for the purpose to shorten the duration of a common cold are not covered.
- Prescription Drug Product when packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.

- Prescription Drug Products prescribed solely to treat hair loss.
- **Prior to Effective Date**: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.
- **Replacement of Prescription Drug Products**. Lost, stolen, or destroyed Prescription Drug Products are not covered.
- **Saline and irrigation solutions**. Saline and irrigation solutions are not covered unless Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Form Section 5: Your Medical Benefits for additional information.
- Smoking cessation products unless they are *FDA*-approved tobacco cessation drugs and products, both of which are provided as a preventive benefit at $0 cost sharing subject to certain exception. Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements. For information on UnitedHealthcare's smoking cessation program, refer to the medical Combined Evidence of Coverage and Disclosure Form in Section 5: Your Medical Benefits or contact Customer Service or visit our web site at **www.myuhc.com**.
- Therapeutic devices or appliances including, but not limited to, support garments and other non-medical substances, insulin pumps and related supplies (these services are provided as durable medical equipment). For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical Combined Evidence of Coverage and Disclosure Form in Section 5: Your Medical Benefits under subsections, for example, *Diabetes Treatment, Durable Medical Equipment (DME), Orthotics and Supplies*, or *Home Health Care*.
- **Unit/Convenience Dosage Forms:** Unit doses, pre-packaged medications, individual packets etc. are not covered unless available in that form only, prior authorized and medically necessary.
- **Worker's Compensation**: Prescription Drug Products for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section 6: Payment Responsibility.

Questions? Call us at 1-800-624-8822 or 711 (TTY)

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P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com

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Your Outpatient Prescription Drug Benefit
Supplement to the Combined Evidence of Coverage and Disclosure Form

Questions? Call the Customer Service Department at 1-800-624-8822.

Zero Cost Share Medications Addendum

UnitedHealthcare of California

As described in this addendum, certain Prescription Drug Products as described in the *PDL Pharmacy Supplement* and *Outpatient Prescription Drug Schedule of Benefits* are modified as stated below.

Because this addendum is part of a legal document (the Group Agreement), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Combined Evidence of Coverage and Disclosure Form (Certificate)* in *Section 10: Definitions,* in the *PDL Pharmacy Supplement* in *Definitions,* and in this addendum below.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of California. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 10: Definitions*.

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

You are not responsible for paying any applicable deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

The following definition is added to *Definitions* in the *PDL Pharmacy Supplement:*

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you). You may find the List of Zero Cost Share Medications by contacting us at **www.myuhc.com** or the telephone number on your ID card.

Understanding Your Outpatient Prescription Drug Benefit

This brochure contains important information for our Members about the UnitedHealthcare outpatient prescription drug benefit. As part of UnitedHealthcare's commitment to you, we want to provide you with the tools and special programs that will help you better understand and utilize your Pharmacy and Prescription Drug Plan. In an effort to eliminate confusion, UnitedHealthcare has provided you with answers for your pharmacy questions such as:

- What is a Formulary/Prescription Drug List (PDL)?
- What is the difference between a Brand-name and Generic drug?
- Who can write my prescription?
- What happens in emergency situations?
- What is the Mail Order Pharmacy Program?
- What is Prior Authorization?

What else should I read to understand my pharmacy benefits?

We want our Members to get the most from their prescription drug benefit plan, so please read this *Supplement to the Combined Evidence of Coverage and Disclosure Form (*"Supplement") carefully. You need to become familiar with the terms used for explaining your coverage, because understanding these terms is essential to understanding your benefit. Along with reading this publication, be sure to review your *Pharmacy Schedule of Benefits.* Your *Pharmacy Schedule of Benefits* provides the details of your particular pharmacy benefit plan, including the exclusions and limitations, applicable Co-payments and UnitedHealthcare's Prior Authorization process. Together, these documents explain your outpatient pharmacy coverage. These documents should be read completely and carefully for a comprehensive understanding of your outpatient pharmacy benefits.

Your medical *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* together with this *Supplement to the Combined Evidence of Coverage and Disclosure Form* and the *Pharmacy Schedule of Benefits* provide the terms and conditions of your benefit coverage. All applicants have a right to view these documents prior to enrollment.

What is covered and not covered?

UnitedHealthcare covers Medically Necessary Prescription Drug Products that are not otherwise excluded from coverage by UnitedHealthcare and Prior Authorization may be required. Refer to your *Pharmacy Schedule of Benefits* for a description of covered Prescription Drug Products as well as the limitations and exclusions for certain Prescription Drug Products.

What is a Formulary/ Prescription Drug List (PDL)?

A PDL is a list that categorizes into Tiers medications or products and contains a broad range of *U.S. Food and Drug Administration* (*FDA*) approved Generic and Brand-name Prescription Drug Products that are covered under your prescription drug benefit. Please refer to your *Pharmacy Schedule of Benefits* for a description of the types of Prescription Drug Products provided at each Tier to know how the formulary (PDL) applies to your prescription drug benefit. This list is subject to our periodic review.

Why are Formularies/(PDLs) necessary?

Prescription costs continue to rise. PDLs list those Prescription Drug Products that offer value while maintaining quality of care to help reduce health care and premium costs.

Who decides which Prescription Drug Products are on the Formulary (PDL)?

Our Prescription Drug List (PDL) Management Committee makes tier placement on our behalf.

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

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

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

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

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

Please remember that the inclusion of a specific drug on the PDL does not guarantee that your licensed Physician will prescribe that drug for treatment of a particular condition.

What if my outpatient Prescription Drug Product is not on the Formulary/(PDL)?

Formularies/PDLs list alternative Prescription Drug Products, which are designed to be safe and effective. If your Prescription Drug Product is not listed on UnitedHealthcare's Formulary/PDL ask your licensed Physician or Network Pharmacist for an alternative Prescription Drug Product that is on the PDL and medically appropriate for you. Non-formulary (PDL) drugs may be Generic or Brand name drugs. For alternative Non-formulary (PDL} Prescription Drug Products, please review the Prior Authorization process in your *Pharmacy Schedule of Benefits*.

How is a Prescription Drug Product added or deleted from the Formulary/PDL?

A Prescription Drug Product must first demonstrate safety and effectiveness to be added to the PDL. Only after this is decided is the cost of the medication considered. Some Prescription Drug Products have similar safety and effectiveness, but one or two are available at a lower cost. In these cases, generally the least costly Prescription Drug Product is added to the Formulary (PDL).

When does the Formulary (PDL) change? If a change occurs, will I have to pay more to use a drug I had been using?

The UnitedHealthcare Pharmacy and Therapeutics Committee, which includes both internal and external doctors and pharmacists, meets regularly to provide clinical reviews of all medications. Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product. If you are prescribed a Maintenance Medication, we will notify you 60 days prior to the change in Tiers that will result in a higher Co-payment. Tier changes that result in a higher copayment will occur no more than six times per plan year. You will receive a written notice 60 days prior to an increase in your Co-payment or Co-insurance due to the change in tier placement if it is moved to a higher tier. The notice will inform you: (a) the new tier, and (b) if prior authorization must be requested by your Physician and determined by UnitedHealthcare of California to be Medically Necessary for the drugs to be covered. Please access www.myuhc.com through the internet or call us at the telephone number on your ID card for the most up-to-date tier status. Tier changes that result in a lower copayment may occur at any time and would be for your benefit. No prior notice would be given to you.

If you are currently taking a Prescription Drug Product which was approved by UnitedHealthcare for a specific medical condition and UnitedHealthcare removes that drug from the PDL, UnitedHealthcare will continue to cover that drug. It will be covered provided your licensed Physician continues to prescribe the drug for your specific medical condition and provided that the drug is appropriately prescribed and continues to be considered safe and effective for treatment of your medical condition. Continued coverage is subject to all terms and conditions of your UnitedHealthcare Health Plan, including the exclusions and limitations of your *Pharmacy Schedule of Benefits*.

Step Therapy

Since UnitedHealthcare offers a comprehensive Formulary (PDL), some Prescription Drug Products will not be covered until one or more Formulary (PDL) alternatives have been tried. Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with a medically appropriate but more affordable medication than was originally prescribed. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate.

Situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Network Physicians will need to request a Step Therapy exception through the Prior Authorization process and to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested Prescription Drug Products as Medically Necessary. Network Physicians may fax step therapy exception requests to UnitedHealthcare.

Exceptions to Step Therapy criteria include:

- No Formulary (PDL) alternative is appropriate and the drug is Medically Necessary for patient care, as determined by UnitedHealthcare and consistent with professional practice.
- The Formulary (PDL) alternative has failed after a therapeutic trial. Your Network Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the PDL alternative.
- The Formulary (PDL) alternative is not appropriate as determined by a review of physician chart notes.
- You have been under treatment and remain stable on a non-Formulary (PDL) prescription drug previously approved by UnitedHealthcare as Medically Necessary that is not excluded from coverage and changing to a Formulary (PDL) drug is medically inappropriate.

If you change your Health Plan, we will not require you to repeat step therapy when the you are already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for your medical condition. You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Generic Prescription Drugs

What is the difference between Generic and Brand-name drugs?

When a new drug is put on the market, for many years it is typically available only under a manufacturer's Brand-name. At first, this new drug is protected by a patent. Only after the patent expires are competing manufacturers allowed to offer the same drug. This type of drug is called a Generic drug.

While the name of the drug may not be familiar to you, a Generic drug has the same medicinal benefits as its Brand- name competitor. In fact, a manufacturer must provide proof to the *FDA* that a Generic drug has the identical active chemical compound as the Brand-name product. A generic product must meet rigid *FDA* standards for strength, quality, purity, and potency.

Only when a Generic drug meets these standards is it considered the brand name drug's equivalent. When the *FDA* approves a new Generic drug, UnitedHealthcare may choose to replace the Brand-name drug on the PDL with the Generic drug.

If you or your provider selects a brand name drug when a generic drug equivalent is available, you will pay the difference in our contracted rate for the name drug and the generic equivalent plus the tier 1 co-payment. The difference in cost does not apply to the out-of-pocket limit or any applicable drug deductible. If you or your provider believes the brand drug is Medically Necessary, you can request an exception through the prior authorization process.

NOTE: If you have a question about our PDL or a particular Prescription Drug Product, please contact UnitedHealthcare at 1-800-624-8822 or 711 (TTY) or visit UnitedHealthcare's web site at **www.myuhc.com.**

Therapeutic substitution of medication (Prescription Drug Product)

If there is no generic equivalent available for a specific Brand-name drug, your licensed Physician may prescribe a 'therapeutic substitute" instead. Unlike a Generic, which has the identical active ingredient as the Brand name version, a therapeutic substitute has a chemical composition that is different but acts similarly in clinical and therapeutic ways when compared to competing Brand-name counterparts. If your licensed Physician specifies therapeutic substitution, you will receive the therapeutic substitution medication and pay the applicable Co-payment (refer to your *Pharmacy Schedule of Benefits* for the amount of your Co-payment).

Filling Your Prescription

Who can write my prescription?

To be eligible for coverage, your Prescription Drug Product must be written by a licensed practitioner.

How do I use my Prescription Drug Product benefit?

Your outpatient Prescription Drug Product benefit helps to cover the cost for some of the outpatient medications prescribed by a licensed practitioner. Using your benefit is simple.

- Obtain your prescription from your licensed practitioner.
- Present your prescription for a covered outpatient Prescription Drug Product and UnitedHealthcare Member ID card at any UnitedHealthcare Network Pharmacy. If ordering by phone, be sure to mention that you are a UnitedHealthcare Member. Note that some Prescription Drug Products must be Prior Authorized by UnitedHealthcare.
- Pay the lower of the applicable Co-payment (refer to your *Pharmacy Schedule of Benefits* for the amount of your Co-payment) for a Prescription Unit or the Network Pharmacy's retail price for the Prescription Drug Product.
- Receive your medication.

How much do I have to pay to get a prescription filled?

Refer to your *Pharmacy Schedule of Benefits* for specific details and Co-payment amounts.

Where do I go to fill a prescription?

UnitedHealthcare has a well-established Network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. For a listing of Network Pharmacies, contact us at 1-800-624-8822 or 711 (TTY) to help locate a Network Pharmacy near you or visit our web site at **www.myuhc.com** for an up-to-date list.

When do I request a refill?

Generally, you may refill a prescription when a minimum of 75 percent of the quantity is consumed based on the days supply.

What is a Maintenance Medication?

A Maintenance Medication is a prescription drug anticipated to be used for six months or more to treat or prevent a chronic condition.

If you require Maintenance Medication, we may direct you to a Mail Order Pharmacy, other than for Specialty Drug Products, which are drugs requiring close monitoring and frequent dose modifications, HIV medications, controlled substances and oral chemotherapy drugs, to obtain those Maintenance Medications.

I take Maintenance Medication on a continuing basis. How can I have my prescriptions filled when I am on vacation?

The most convenient and affordable way to obtain Maintenance Medications is to obtain a 90-day supply through our Mail Order Pharmacy Program (for additional details refer to the Mail Order Pharmacy Program section in this document). It is important to plan ahead, because it takes approximately seven days to receive your 90-day supply from the mail service program. Early refills for vacation are also available from Participating Pharmacies in certain circumstances – talk with your pharmacist about obtaining a vacation override. Our Customer Service can also help you with planning for your medication needs while traveling call 1-800-624-8822 or 711 (TTY).

What if I am sick and need a prescription when I'm away from home?

If you are sick and need an outpatient Prescription Drug Product filled when away from home, you may visit one of our Network Pharmacies within our national pharmacy Network and receive the Prescription Drug Product for the applicable Co-payment. For the nearest Network pharmacy, contact us at 1-800-624-8822 or 711 (TTY) or visit our web site at **www.myuhc.com**.

What happens in an emergency situation?

While in most circumstances you must fill your prescription at a Network Pharmacy, you may fill your prescription for an outpatient Prescription Drug Product at an Out-of-Network Pharmacy in an Emergency or Urgent situation. In such situations, you must pay the total cost of the Prescription Drug Product at the time you receive the Prescription Drug Product and you will be reimbursed by UnitedHealthcare for the cost of the Prescription Drug Product, less the applicable Co-payment. However, if UnitedHealthcare decides that you obtained the Prescription Drug Product from an Out –of-Network Pharmacy and it is determined the care did not meet the

definitions of an Emergency Health Care Service or Urgently Needed Services, you will be responsible for the total cost of the Prescription Drug Product and UnitedHealthcare will not reimburse you.

To obtain reimbursement for Emergency Health Care or Urgently Needed Prescription Drug Product, you must follow the instructions below under "How do I obtain reimbursement?". You are only eligible for reimbursement for prescriptions related to urgent or emergency situations as defined by UnitedHealthcare (refer to your medical *Combined Evidence of Coverage and Disclosure Form*) minus the applicable Co-payment.

How do I obtain reimbursement?

Contact the Customer Service department at 1-800-624-8822 or 711 (TTY) or visit UnitedHealthcare's web site at **www.myuhc.com** to obtain the Direct Reimbursement Form. Provide the following: Direct Member Reimbursement Form, copies of the prescription receipts showing the prescription number, name of the medication, date filled, pharmacy name, name of the Member for whom the prescription was written, proof of payment and a description of why a UnitedHealthcare Participating Pharmacy was not available. Send these documents to: UnitedHealthcare Pharmacy Department, P.O. Box 29077, Hot Springs, AR 71093.

You should submit the Direct Reimbursement Form within 90 days, or as soon as reasonably possible from the date of service. Payment will be forwarded to you once your request for reimbursement is decided by UnitedHealthcare to be appropriate.

Emergency Override

UnitedHealthcare will cover a 5-day emergency supply of a medication once during a calendar year while a prior authorization review is in progress.

When I fill a Prescription Drug Product, how much medication do I receive?

For a single Co-payment, Members receive one Prescription Unit which represents a maximum of one month's (31 days supply) fill of outpatient prescription medication that can be obtained at one time. For most oral medications, a Prescription Unit is up to a 31-day supply of medication.

Prescription Drug Products dispensed in quantities other than the 31-day supply maximum are listed below:

- **Medications with quantity limitations:** The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. These quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. For example, antibiotics typically require less than a 31 day supply; and certain drugs such as controlled substances and migraine medications may be limited due to the expectation of patient need and in accordance with manufacturer's recommended dosages. Drugs with quantity limitations may be dispensed in greater quantities if Medically Necessary and Prior Authorized by UnitedHealthcare.
- **Defined or pre-packaged units of medications:** Prescription Drug Products such as inhalers, eye drops, creams, or other types of medications or Prescription Drug Products that are normally dispensed in pre-packaged or defined units of 31 day or less will be considered a single Prescription Unit.
- **Medication obtained through UnitedHealthcare's Mail Order Program:** If you use the UnitedHealthcare Mail Order Pharmacy, you will receive three Prescription Units or up to a 90-day supply of Maintenance Medications (except for pre-packaged medications or Prescription Drug Products as described above). When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.

UnitedHealthcare's Mail Order Pharmacy Program

What is the Mail Order Pharmacy Program?

UnitedHealthcare offers a Mail Order Pharmacy Program through *Optum Rx®.* The Mail Order Pharmacy Program provides convenient service and savings on Maintenance Medications that you may take on a regular basis by allowing you to purchase certain drugs for receipt by mail. You get quality medications mailed directly to your home or address of your choice within the United States, in a discreetly labeled envelope to ensure privacy and safety. Standard shipping and handling is at no additional charge.

If you use our Mail Order Pharmacy Program, you will generally get your Maintenance Medication within (7) seven working days after receipt of your order. All orders are shipped in discreetly labeled envelopes for privacy and safety.

Here's how to fill prescriptions through the Mail Order Pharmacy Program.

1. Call your licensed Physician to obtain a new prescription for each medication. When you call, ask the Physician to write the prescription for a 90-day supply which represents three Prescription Units with up to

three additional refills. The doctor will tell you when to pick up the written prescription. (Note: Optum Rx® must have a new prescription to process any new Mail Order request.)

2. After picking up the prescription, complete the Mail Order Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, call UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711 (TTY). You can also find the form at the web site address **www.optumrx.com**.)
3. Enclose the prescription and appropriate Co-payment via check, money order, or credit card. Your *Pharmacy Schedule of Benefits* will have the applicable Co-payment for the Mail Order Pharmacy Program. Make the check or money order payable to ***Optum Rx***®. No cash please.

When you receive your prescription, you will get detailed instructions that tell you how to take the medication, possible side effects and any other important information about the medication. If you have questions, registered pharmacists are available to help you by calling Optum Rx® at 1-800-562-6223 or 711 (TTY).

Important Tip: If you are starting a new Prescription Drug Product, please request two prescriptions from your licensed physician. Have one filled immediately at a Network Pharmacy while mailing the second prescription to UnitedHealthcare's Mail Order Pharmacy. Once you receive your medication through the Mail Order Pharmacy Program, you should stop filling the prescription at the Network Pharmacy.

Designated Pharmacies

What is a Designated Pharmacy?

If you require certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. There are both retail and mail pharmacies in the Designated Pharmacy network. Note that not all contracted retail pharmacies are in the Designated Pharmacy network. Only retail pharmacies that are in the Designated Pharmacy network will provide access to these Specialty Prescription Drug Products. If you choose not to obtain your Specialty Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program through the Internet at www.myuhc.com or by calling the telephone number on your ID card. If you want to opt-out of the program and fill your Specialty Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Specialty Prescription Drug Product and no Benefits will be paid unless we authorize the use of a Network Pharmacy including in an urgent situation.

Prior Authorization

What is Prior Authorization?

UnitedHealthcare covers Medically Necessary Prescription Drug Products when prescribed by a licensed Physician and Prior Authorization may be required. For example, medications when prescribed for cosmetic purposes, such as wrinkle creams, are not generally covered. Medication quantities may also be limited to ensure that they are being used safely and effectively, and Co-payments, exclusions and limitations vary. Please be sure to read your *Pharmacy Schedule of Benefits,* which describes the details of your prescription drug coverage, including the types of medications that require Prior Authorization, and that are limited or excluded. Prescriptions that require Prior Authorization will be charged at the applicable Co-payment if approved.

We want to make sure our Members receive optimal care and appropriate medication use is a big part of maintaining your overall health. That is why we have systems in place to make sure your medication is Medically Necessary and prescribed according to treatment guidelines consistent with standard professional practice. We also want to make sure you are not taking more medication than you need or are taking medication for a longer period of time than is necessary, and that you are receiving follow-up care. UnitedHealthcare reserves the right to require Prior Authorization and/or limit the quantity of any prescription. The following is a list of factors that UnitedHealthcare takes into consideration when completing a Prior Authorization review:

- The prescription is for the treatment of a covered medical condition and the expected beneficial effects of the prescription outweigh the harmful effects.
- There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome.
- The prescription represents the most cost-effective method to treat the medical condition.
- The prescription drug is prescribed according to established, documented and approved indications that are supported by the weight of scientific evidence.

What do I do if I need Prior Authorization?

We understand that situations may arise in which it may be Medically Necessary to take a medication above the preset limits or for a particular condition/circumstance. In these instances, since your licensed physician understands your medical history and health conditions, he/she can request Prior Authorization. We have made the process simple and easy. Your licensed physician may electronically or by fax send the Prior Authorization request to Optum Rx®, which is UnitedHealthcare's pharmacy benefit manager. The Prior Authorization staff of qualified pharmacists and technicians is available Monday through Friday from 5:00 a.m. to 10:00 p.m. PST and Saturday from 6:00 a.m. to 3:00 p.m. PST to assist licensed physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your licensed physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested Prescription Drug Product meets plan criteria.

When a Prescription Drug Product is not listed on the PDL, you or your representative may request an exception to gain access to the Prescription Drug Product if Medically Necessary and Prior Authorized. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination during the required timeframe.

- **In the case of a standard exception request**, we will notify the Member or the Member's designee or the Member's prescribing provider of the Benefit determination no later than 72 hours following receipt of the prior authorization request for a Non-Formulary (PDL) drug. When we grant a standard exception request, we will provide coverage of the Prescription Drug Product for the duration of the prescription, including refills.
- **In the case of an expedited exception request based on exigent circumstances**, we will notify the Member or the Member's designee or the Member's prescribing provider of the Benefit determination no later than 24 hours following receipt of the Prior Authorization request for a Non-Formulary (PDL) drug. When we grant an exception based on exigent circumstances, we will provide coverage of the Prescription Drug Product (including refills) for the duration of the exigency. Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when the Member is undergoing a current course of treatment using a Prescription Drug Product that is not on the Formulary (PDL).
- **External exception request review.** If we deny a request for a standard exception or for an expedited exception, the Member, the Member's designee, or the Member's prescribing provider may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. We will provide notice of how to proceed with a request in the denial letter. A denial of a Prior Authorization request for a Non-Formulary (PDL) drug exception is subject to review by an Independent Review Organization (IRO). The Independent Review Organization will make a determination on the external exception request and notify the Member or the Member's designee and the prescribing provider of the Benefit determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request. If the Independent Review Organization grants an external exception review of a standard exception request, we will provide coverage of the Prescription Drug Product that is not on the Formulary (PDL). If the Independent Review Organization grants an external exception review of an expedited exception request, we will provide coverage of the Prescription Drug Product that is not on the Formulary (PDL) for the duration of the exigency. Please note that the external review process is in addition to the Member's right to file a grievance or request an independent review administered by the Department of Managed Health Care.
- For more information regarding filing a grievance and independent review administered by the Department of Managed Health Care, please refer to Section 8 of the *Combined Evidence of Coverage and Disclosure Form* for more information.

Does this plan limit or exclude certain drugs my health care provider may prescribe or encourage substitutions for some drugs?

Your UnitedHealthcare pharmacy benefit provides you access to a wide range of *FDA*-approved brand and generic medication. The Formulary (PDL) is developed with the input from licensed physicians and pharmacists and is based on assessment of the drug's quality, safety, effectiveness and cost. If a medication is not included

on the Formulary (PDL), it may be because the Plan's Formulary (PDL) includes other drugs that are frequently prescribed for the same condition as those that are not included on the Formulary (PDL). For example, UnitedHealthcare may have an equivalent Generic medication on the Formulary (PDL) for the Brand-name medication prescribed by your licensed physician. It is also important to remember there may be other options available for treating a particular medical condition. Non-Formulary (PDL) medications may require Prior Authorization and will be approved when Medically Necessary unless otherwise excluded by UnitedHealthcare as described in the Exclusions and Limitations Section of the *Pharmacy Schedule of Benefits*. Refer to the Section entitled "What do I do if I need Prior Authorization" in this document for additional information.

What should I do if I want to appeal a Prior Authorization decision?

As a UnitedHealthcare Member, you have the right to appeal any Prior Authorization decision. Contact Customer Service at 1-800-624-8822 or 711 (TTY) for details on the Prior Authorization or appeals process. Please refer to your medical *Combined Evidence of Coverage and Disclosure Form* for more details on the appeals process and the expedited review process.

Rebates and Other Payments

We may receive rebates for certain drugs included on the PDL. We may pass a portion of these rebates on to you, and they may be taken into account in determining your Co-payments and/or Co-insurance.

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

Coupons, Incentives and Other Communications

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

Variable Co-payment Program

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

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

Special Programs

We may have certain programs in which you may receive an enhanced benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network

Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at [www.myuhc.com] or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at a Retail Network Pharmacy.

Definitions

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

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

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

If you or your provider believes the requested Prescription Drug Product is Medically Necessary, you can request an exception through the prior authorization process.

Annual Drug Deductible - the amount you are required to pay for covered Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to your *Pharmacy Schedule of Benefits* to see if you have an Annual Drug Deductible and how it applies.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, data sources such as Medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Calendar Year – The time period beginning on January 1 and ending on December 31.

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

Contract Year – The twelve-month period that begins on the first day of the month the Agreement become effective

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

Generic - a Prescription Drug Product that is (1) the same as a Brand Name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use. It contains the identical amounts of the same active ingredient(s) as the Brand Name product. This definition applies to *FDA* approved generic drugs. (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

List of Preventive Medications – a list that defines certain Prescription Drug products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at [www.myuhc.com] or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product which is anticipated to be used for six months or more to treat or prevent a chronic condition. You may learn if a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

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

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

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

Non-PDL Drug - A drug that is not included on the PDL.

Out-of-Network Pharmacy – A pharmacy that has NOT contracted with UnitedHealthcare to provide outpatient prescription drugs to our Members.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

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

Prescription Drug List (PDL) - a list that categorizes into Tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). The PDL does not include all prescription medications. You may determine to which Tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - The committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific Tiers.

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets; and
  - lancets and lancet devices.

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

Prescription Unit – The maximum amount (quantity) of prescription medication that may be dispensed per single Co-payment. For most oral medications, a Prescription Unit represents up to a 31-day supply of medication. The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. Quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. Prescriptions that are normally dispensed in pre-packaged or commercially available units of 31 days or less will be considered a single Prescription Unit, including but not limited to, one inhaler, one vial of ophthalmic medication, one tube of topical ointment or cream.

Preventive Care Medications or PPACA Zero Cost Share Preventive Care Medications – The medications that are obtained at a Participating Pharmacy with a prescription by a UnitedHealthcare Participating Provider and that are payable at 100% of the Prescription Unit cost (without application of any Co-payment, or annual Deductible as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United Preventive Services Task Force.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including but not limited to *FDA*-approved contraceptive methods.

You may learn if a drug is a Preventive Care Medication PDL through the internet at **www.myuhc.com** or by calling Customer Service at 1-800-624-8822 or 711 (TTY).

Prior Authorization – UnitedHealthcare's review process that decides whether a prescription drug is Medically Necessary and not otherwise excluded prior to the Member receiving the prescription drug.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.* Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Tier - The tiers for Outpatient Prescription Drugs are defined as follows, per California state law:

- Tier 1- consists of most Generic drugs and low-cost preferred Brand-name drugs.
- Tier 2 - consists of non-preferred Generic drugs, preferred Brand-name drugs and any other drugs recommended by our pharmacy and therapeutics committee based on safety, efficacy, and cost.
- Tier 3 – consists of non-preferred Brand-name drug or drugs that are recommended by our pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
- Tier 4 – consists of drugs that are biologics, drugs that the *FDA* or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the insured to have special training or clinical monitoring for self-administration, or drugs that cost the health insurer more than six hundred dollars ($600) net of rebates for a one-month supply.

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

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

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

Pharmacy Listing

For the most up to date list visit the web site at www.myuhc.com

Questions? Call UnitedHealthcare Customer Service at 1-800-624-8822 (HMO) or 711 (TTY).

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com

PCA880520-000
Effective 1/1/2023

Acupuncture Schedule of Benefits
Provided by ACN Group of California, Inc.

UnitedHealthcare®

Benefit Plan:

Refer to the Medical Schedule of Benefits for Copayment per Visit.

This program is provided through an arrangement with the ACN Group of California, Inc. dba OptumHealth Physical Health of California (OptumHealth). OptumHealth monitors the quality of the care provided by participating OptumHealth providers.

How to Use the Program

With OptumHealth, you have access to more than 950 credentialed acupuncturists servicing California. You are not required to predesignate an OptumHealth provider, but must obtain a medical referral from your primary care physician prior to seeking acupuncture services.

Acupuncture Benefits

Benefits include acupuncture services that are Medically Necessary services, requiring a referral, and rendered by an OptumHealth participating provider. In the case of acupuncture services, the services must be for Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions.

Calculation of Annual Deductible Limits

Each visit to an OptumHealth participating provider, as described below, requires a copayment and/or deductible by the member.

Acupuncture Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without acupuncture treatment, the adjunctive therapy will count as an office visit toward any deductible. If an examination or re-examination is supplied without acupuncture treatment, the examination or re-examination will count as an office visit toward any deductible.

Provider Eligibility

OptumHealth only contracts with duly licensed California acupuncturists. Members must use OptumHealth participating providers to receive their maximum benefit.

Types of Covered Services

Acupuncture Services

1. An initial examination is performed by the OptumHealth participating acupuncturist to determine the nature of the member's problem and to provided or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a member if the member seeks services from an OptumHealth participating acupuncturist for any injury, illness, disease, functional disorder or condition with regard to which the member is not, at that time, receiving services from an OptumHealth participating acupuncturist. A copayment will be required for such examination.
2. Subsequent office visits, as set forth in a treatment plan, may involve acupuncture treatment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.
3. A re-examination may be performed by the OptumHealth participating acupuncturist to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

Important OptumHealth Addresses:

Member Correspondence

OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009

Grievances and Complaints

OptumHealth Physical Health of California
Attn.: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168-0009

Questions? Call OptumHealth's Customer Service Department: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PST

www.myoptumhealthphysicalhealthofca.com

Exclusions and Limitations

Benefits do not include services that are not described under the Covered Services or contained elsewhere in the Supplement to the Evidence of Coverage (EOC) provided to a member. The following accommodations, services, supplies, and other items are specifically excluded from coverage as referenced in the EOC:

1. Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care.
4. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;
5. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
6. Experimental or investigative services unless required by an external, independent review panel as described in 11.5 of the EOC;
7. Services provided at a hospital or other facility outside of a Participating Provider's facility;
8. Holistic or homeopathic care including drugs and ecological or environmental medicine;
9. Services involving the use of herbs and herbal remedies;
10. Treatment for asthma or addiction (including but not limited to smoking cessation);
11. Any services or treatments caused by or arising out of the course of employment and are covered under Workers' Compensation;
12. Transportation to and from a provider;
13. Drugs or medicines;
14. Intravenous injections or solutions;
15. Charges for services provided by a Provider to his or her family Member(s);
16. Charges for care or services provided before the effective date of the Member's coverage under the Group Agreement, or after the termination of the Member's coverage under the Group Agreement, except as otherwise provided in the Group Agreement;
17. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
18. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, and treatment for an educational requirement;
19. Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services or Urgent Services, or other services authorized by Health Plan;
20. Ambulance services;
21. Surgical services;
22. Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder or Acupuncture Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;
23. Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child; and
24. Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Medical Emergencies are covered by the Member's medical plan rather than OptumHealth.
25. Services provided without an authorized referral from your Primary Care Physician or UnitedHealthcare. (Refer to Section 2 of the *Combined Evidence of Coverage and Disclosure Form*

PCA809710-003
QBV, QF8, QG4, QGM,
U00, U3O, UO4, UO8, UTX

Chiropractic Schedule of Benefits Offered by OptumHealth Physical Health of California, Inc.

UnitedHealthcare®

Benefit Plan:

$15 Copayment per Visit

20 Visit Annual Maximum Benefit

Your Group makes available to you and your eligible dependents a complementary health benefits program for chiropractic. This program is provided through an arrangement with the ACN Group of California, Inc. dba OptumHealth Physical Health (OptumHealth). OptumHealth monitors the quality of the care provided by participating OptumHealth providers.

How to Use the Program

With OptumHealth, you have direct access to more than 3,500 credentialed chiropractors servicing California. You are not required to predesignate an OptumHealth provider or to obtain a medical referral from your primary care physician prior to seeking chiropractic services. Additionally, you may change participating chiropractors at any time.

Our program is designed for your convenience. You simply pay your copayment or coinsurance at each visit. There are no claim forms to fill out. Your OptumHealth provider coordinates all services and billing directly with OptumHealth.

Annual Benefits

Benefits include chiropractic services that are Medically Necessary services rendered by an OptumHealth participating provider. In the case of chiropractic services, the services must be for Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Deductible Limits

Each visit to an OptumHealth participating provider, as described below, requires a copayment by the member. A maximum number of visits to an OptumHealth participating chiropractor per calendar year will apply to each member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without a chiropractic adjustment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit toward the maximum benefit.

Provider Eligibility

OptumHealth only contracts with duly licensed California chiropractors. Members must use OptumHealth participating providers to receive their maximum benefit.

Types of Covered Services

Chiropractic Services

1. An initial examination is performed by the OptumHealth participating chiropractor to determine the nature of the member's problem, and to provide, or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a member if the member seeks services from an OptumHealth participating chiropractor for any injury, illness, disease, functional disorder or condition with regard to which the member is not, at the time, receiving services from the OptumHealth participating chiropractor. A copayment will be required for such examination.

   Subsequent office visits, as set forth in a treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.
2. Adjunctive therapy, as set forth in a treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.
3. A re-examination may be performed by the OptumHealth participating chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.
4. X-rays and laboratory tests are a covered benefit to examine any aspect of the member's condition,

if performed by an OptumHealth participating chiropractor.

5. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by an OptumHealth participating chiropractor.

Important OptumHealth Addresses:

Member Correspondence

OptumHealth of California, Inc.
P.O. Box 880009
San Diego, CA 92168-0009

Grievances and Complaints

OptumHealth of California, Inc.
Attn.: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168-0009

Exclusions and Limitations

Benefits do not include services that are not described under the Covered Services or contained elsewhere in the Supplement to the Evidence of Coverage (EOC) provided to a member. The following accommodations, services, supplies, and other items are specifically excluded from coverage as referenced in the EOC:

1. Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;
4. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
5. Experimental or investigative services unless required by an external, independent review panel as described in 16.5 of the EOC;
6. Services provided at a hospital or other facility outside of a Participating Provider's facility;
7. Holistic or homeopathic care including drugs and ecological or environmental medicine;
8. Services involving the use of herbs and herbal remedies;
9. Treatment for asthma or addiction (including but not limited to smoking cessation);
10. Any services or treatments caused by or arising out of the course of employment and are covered under Workers' Compensation;
11. Transportation to and from a provider;
12. Drugs or medicines;
13. Intravenous injections or solutions;
14. Charges for services provided by a Provider to his or her family Member(s);
15. Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
16. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
17. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, and treatment for an educational requirement;
18. Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services or Urgent Services, or other services authorized by Health Plan;
19. Ambulance services;
20. Surgical services;
21. Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;
22. Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child; and
23. Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment**.** Medical Emergencies are covered by the Member's medical plan rather than OptumHealth.
24. Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care

Website Address:
http://www.myoptumhealthphysicalhealthofca.com

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com

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PZ0

CALIFORNIA

UnitedHealthcare of California
Offered by UNITEDHEALTHCARE VISION NETWORK

Supplement to the Combined Evidence of Coverage and Disclosure Form

Pediatric Vision Care Services

Pediatric Vision Care Services

UnitedHealthcare of California

SUPPLEMENT TO THE COMBINED EVIDENCE OF COVERAGE and DISCLOSURE FORM

This Supplement to the Group Services Agreement is issued to the Employer Group and provides Benefits for Vision Care Services, as described below, for Members under the age of 19. Benefits under this Supplement terminate on the date the Member reaches the age of 19.

Because this Supplement is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Evidence of Coverage and Disclosure Form* in *Section 10: DEFINITIONS* or in this Supplement in *Section 4: Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of California. When we use the words "you" and "your" we are referring to people who are Covered Members, as the term is defined in the *Evidence of Coverage* in *Section 10: DEFINTIONS*.

_____

(Name and Title)

Section 1: Covered Services for Pediatric Vision Care Services

Covered Services are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at **www.myuhcvision.com**.

Benefits are not available for Vision Care Services that are not provided by a UnitedHealthcare Vision Network Vision Care Provider.

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider, you will be required to pay any Co-payments at the time of service.

Benefits:

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

Out-of-Pocket Limit - Any amount you pay in Co-payments for Vision Care Services under this Supplement applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Supplement are not subject to any Annual Deductible stated in the medical *Schedule of Benefits.*

Benefit Description

Benefits

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

Frequency of Service Limits

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

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.

- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Dilation when professionally indicated
- Diagnosis/prognosis.
- Specific recommendations.
- Dilation, if professionally indicated.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Low Vision Service

The low vision benefit is available to you if have severe visual problems that cannot be corrected with regular lenses. This benefit is available where a Vision Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Provider and not by us.

This benefit includes:

- Low Vision Testing: Complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low Vision Therapy: Subsequent low vision therapy if prescribed.
- The frequency of your testing and therapy will be increased when one of the following occurs:
- A .50 diopter or more change in prescription.
- A shift in axis of astigmatism of five percent (5%) or more.
- A difference in vertical prism greater than one prism diopter.
- Replacement of lenses and/or frames due to them being lost or stolen.
- You have diabetes or hypertension.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to choose only one of either eyeglasses (includes eyeglass lenses and frames) or *Contact Lenses*. If you choose both eyeglasses and contact lenses, we will advise you that we will pay for one of these benefits and you need to advise us which one you wish to have free of any charge.

Lenses include choice of glass or plastic lenses, all lens powers.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses (includes eyeglass lenses and frames) or *Contact Lenses*. If you choose both eyeglasses and contact lenses, we will advise you that we will pay for one of these benefits and you need to advise us which one you wish to have free of any charge.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Covered Services include the fitting/evaluation fees and contacts.

You are eligible to choose only one of either eyeglasses (includes eyeglass lenses and frames) or *Contact Lenses*. If you choose both eyeglasses and contact lenses, we will advise you that we will pay for one of these benefits and you need to advise us which one you wish to have free of any charge.

Necessary Contact Lenses

Covered Services are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological Myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic Disorders.

Schedule of Benefits

Vision Care Service	**Frequency of Service**	**Amount You Pay for Benefit** ***(The Amount You Pay)***
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	No charge Not subject to the payment of the Annual Deductible
Eyeglass Lenses - one pair	Once per year.	
• *Single Vision*		20% of billed charge Not subject to the payment of the Annual Deductible
• *Bifocal*		20% of billed charge Not subject to the payment of the Annual Deductible
• *Trifocal*		20% of billed charge Not subject to the payment of the Annual Deductible

Vision Care Service	Frequency of Service	Amount You Pay for Benefit *(The Amount You Pay)*
• *Lenticular*		20% of billed charge Not subject to the payment of the Annual Deductible
Lens Extras		
• Polycarbonate lenses	Once per year	None Not subject to the payment of the Annual Deductible
• Standard scratch-resistant coating	Once per year	None Not subject to the payment of the Annual Deductible
Eyeglass Frames	Once per year.	20% of billed charge Not subject to the payment of the Annual Deductible
• Contact Lens Fitting & Evaluation	Once per year	
• Covered Contact Lens Selection in lieu of eyeglasses	Limited to a one year supply.	20% of billed charge Not subject to the payment of the Annual Deductible
• Necessary Contact Lens*es*	Limited to a one year supply once per year.	No charge Not subject to the payment of the Annual Deductible.
Low Vision Services Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.		
• Low vision testing	Once every 24 months	No charge Not subject to the payment of the Annual Deductible.
• Low vision therapy		20% of billed charge Not subject to the payment of the Annual Deductible
• Low vision aids such as high-power spectacles, magnifiers and telescopes		20% of billed charge Not subject to the payment of the Annual Deductible.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Supplement under *Section 1: Covered Services for Pediatric Vision Care Services*, Covered Services are not provided under this Supplement for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Covered Services are available as stated in the *Combined Evidence of Coverage and Disclosure Form.*
2. Vision Care Services received from a non- UnitedHealthcare Vision Network Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Covered Services for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Low Vision Care Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Member's name.
- Covered Member's identification number from the ID card.
- Covered Member's date of birth.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 10: DEFINITIONS* of the *Combined Evidence of Coverage and Disclosure Form*:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable share of cost

UnitedHealthcare Vision Network - the provider network through which your access to Vision Care Providers is arranged.

Vision Care Provider - any participating optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services

Vision Care Service - any service or item listed in this Supplement in *Section 1: Covered Services for Pediatric Vision Care Services*

PCA883309-001

NICE Plan Codes: 1BN, 10V, 10W, 10X. 10Y, 16O, 17O, 18O, 19O, 1AK, 1AM, 1AN, 1AO, 1BO, 1BP, 1BQ, 1DM, 1DP, 1DQ, 1DR, 1Q1, 1R1, 1T1, 1U1
Cal Choice Plan Codes: 1GB, 1D9, 1GP, 1HB, 1I8,1T8
PRIME Plan Codes: CP-SM, CP-SG, CP-SU, CW-YE, CW-YF, CW-YG

Effective 1/1/23

Customer Service:
1-800-839-3242
www.myuhcvision.com

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CALIFORNIA

UnitedHealthcare of California
Offered by Dental Benefit Providers of California, Inc.

Supplement to the Combined Evidence of Coverage and Disclosure Form

Pediatric Dental Coverage

Dental Benefit Providers of California, Inc.

Supplement to the Combined Evidence of Coverage and Disclosure Form

THIS IS A SUPPLEMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA MEDICAL COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Your UnitedHealthcare of California Medical Plan includes Pediatric Dental coverage through Dental Benefit Providers of California, Inc., ("DBPCA" or "the Company"). This Supplement to the Combined Evidence of Coverage and Disclosure Form will help you become more familiar with your Pediatric Dental benefits. This Supplement to the Combined Evidence of Coverage and Disclosure Form ("EOC") should be used in conjunction with your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. It is a legal document that explains your Pediatric Dental benefits and should answer many important questions about your benefits.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your Supplement to the Combined Evidence of Coverage and Disclosure Form is a key to making the most of your membership, and it should be read completely and carefully. All applicants have a right to view this document prior to enrollment. Individuals with special Pediatric Dental health needs should carefully read those sections that apply to them.

The Group Agreement is delivered in and governed by the laws of the State of California.

Please review both the Schedule of Benefits as to benefits, co-payments, co-insurance, limitations and the Supplement to the Combined Evidence of Coverage and Disclosure Form for details as to the benefits, including exclusions and to coverage.

Introduction

How To Use This Supplement to the EOC

This Supplement to the EOC should be read and re-read in its entirety. Many of the provisions of this Supplement to the EOC and the attached Schedule of Covered Dental Services are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your Supplement to the EOC and Schedule of Covered Dental Services may be modified by the attachment of Addendums and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this Supplement to the EOC or Schedule of Covered Dental Services may have been changed.

Many words used in this EOC and Schedule of Covered Dental Services have special meanings. These words will appear capitalized and are defined for you in Section 1: Definitions. By reviewing these definitions, you will have a clearer understanding of your Supplement to the EOC and Schedule of Covered Dental Services.

When we use the words "we," "us," and "our" in this document, we are referring to Dental Benefit Providers of California, Inc. When we use the words "you" and "your" we are referring to people who are Members as the term is defined in Section 1: Definitions.

Dental Services Covered

In order for Dental Services to be Covered, you must obtain all Dental Services directly from or through a Participating Dentist.

You must always verify the participation status of a Dentist prior to seeking services. From time to time, the participation status of a Dentist may change. You can verify the participation status by calling the Company and/or Dentist. If necessary, the Company can provide assistance in referring you to Participating Dentists. If you use a Dentist that is not a Participating Dentist, you will be required to pay the entire bill for the services you received.

Only Necessary Dental Services are Covered under the Group Agreement. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is Covered under the Group Agreement.

The Company has discretion in interpreting the benefits Covered under the Group Agreement and the other terms, conditions, limitations and exclusions set out in the Group Agreement and in making factual determinations related to the Group Agreement and its benefits. The Company may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Group Agreement.

The Company reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Group Agreement, as permitted by law, without the approval of Members. No person or entity has any authority to make any oral changes or amendments to the Group Agreement.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency, provide Coverage for services, which would otherwise not be Covered. The fact that the Company does so in any particular case will not in any way be deemed to require it to do so in other similar cases.

The Company may arrange for various persons or entities to provide administrative services in regard to the Group Agreement, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by Members. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Company may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Group Agreement. You are obligated to provide this information. Failure to provide required information may result in Coverage being delayed or denied.

Important Note About Services

The Company does not provide Dental Services or practice dentistry. Rather, the Company arranges for providers of Dental Services to participate in a Network. Participating Dentists are independent practitioners and are not employees of the Company. The Company compensates its' providers using direct reimbursement, discounted fee for service, fee for service and capitation. The dentist also receives compensation from Company enrollees who pay a defined "Co-payment" for specific Dental Services. In addition, there may be occasions when a program may provide supplemental payments for specific Dental Procedures. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

The payment methods used to pay any specific Participating Dentist vary. The method may also change at the time providers renew their Group Agreements with the Company. If you have questions about whether there are any financial incentives in your Participating Dentist's Group Agreement with the Company, please contact the Company at the telephone number on your ID card. The Company can advise you whether your Participating Dentist is paid by any financial incentive, however, the specific terms, including rates of payment, are confidential and cannot be disclosed.

The Dentist-patient relationship is between you and your Dentist. This means that:

- You are responsible for choosing your own Dentist.
- You must decide if any Dentist treating you is right for you. This includes Participating Dentists who you choose or providers to whom you have been referred.
- You must decide with your Dentist what care you should receive.
- Your Dentist is solely responsible for the quality of the care you receive.

The Company makes decisions about eligibility and if a benefit is a Covered benefit under the Group Agreement. These decisions are administrative decisions. The Company is not liable for any act or omission of a provider of Dental Services.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the providers have no way of knowing that you are Covered by the Company and you may receive a bill.

Contact the Company

Throughout this Supplement to the EOC you will find statements that encourage you to contact the Company for further information. Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Company at the telephone number stated on your ID card.

Translation Service

The Company uses a telephone translation service for almost 140 languages and dialects. That is in addition to select Customer Service representatives who are fluent in Spanish.

Hearing and Speech Impaired Telephone Lines

The Company uses a dedicated telephone number for the hearing and speech impaired. This telephone number is 1-877-735-2929.

Public Policy Committee

The Dental Plan has established a Public Policy Committee comprised of four (4) Members of the Dental Plan, one (1) Dental Plan Dentist, an officer of the Dental Plan, and a member of the Dental Plan’s Board of Directors.

The purpose of this Committee is to allow Members to make suggestions to improve the comfort, dignity, and convenience of the Members, and to indicate to the Dental Plan those areas of service in which care may be inadequate. To communicate with a member of the Committee, a Member may write the Dental Plan at P.O. Box 25817, Santa Ana, California 92799-5187 or telephone the Dental Plan at 1-800-228-3384, 1-877-735-2929 (TTY), and he or she will be given all necessary information to contact a member of the committee. Every Member's suggestion or comments will receive prompt attention.

To participate in the Dental Plan’s Public Policy Committee, please submit a written request to:

Quality Management

Dental Benefit Providers of California, Inc.

P.O. Box 25817
Santa Ana, California 92799-5187

Table of Contents

Section 1: Definitions

This Section defines the terms used throughout this Supplement to the EOC and Schedule of Covered Dental Services and is not intended to describe Covered or uncovered services.

Amendment - any attached description of additional or alternative provisions to the Group Agreement. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Group Agreement except for those which are specifically amended.

CDT Codes - the Current Dental Terminology for the current Code on Dental Procedures and Nomenclature (the Code). The Code has been designated as the national standard for reporting dental services by the Federal Government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), and is currently recognized by third party payors nationwide.

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

Group Agreement Charge - the sum of the Premiums for all eligible Subscribers and Enrolled Dependents Covered under the Group Agreement.

Co-payment - the charge you are required to pay for certain Dental Services payable under the Group Agreement. A Co-payment is a defined dollar amount. You are responsible for the payment of any Co-payment directly to the provider of the Dental Service at the time of service or when billed by the provider.

Coverage or Covered - the entitlement by a Member to Dental Services Covered under the Group Agreement, subject to the terms, conditions, limitations and exclusions of the Group Agreement. Dental Services must be provided: (1.) when the Group Agreement is in effect; and (2.) prior to the date that any of the individual termination conditions as stated in Section 3: Termination of Coverage occur; and (3.) only when the recipient is a Member and meets all eligibility requirements specified in the Group Agreement.

Dental Service or Dental Procedures - dental care or treatment provided by a Dentist to a Member while the Group Agreement is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dependent – is under the age of 19years and include the Subscriber's legal spouse, Domestic Partner, and dependent child of the Subscriber or the Subscriber's spouse or Domestic Partner. The Subscriber agrees to reimburse the Company for any Dental Services provided to the child at a time when the child did not meet these conditions. The term Dependent also includes a child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Employer Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Experimental or Investigational Services - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding Coverage in a particular case, is determined to be:

A. 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; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. 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; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - are defined as services provided outside the U.S. and U.S. territories.

Member – the Subscriber and Enrolled Dependent(s), who are under the age of 19 while Coverage of such person under the Group Agreement is in effect. References to you and your throughout this Supplement to the EOC are references to a Member.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate; and

A. necessary to meet the basic dental needs of the Member; and

B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and

C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of the Member or his or her Dentist; and

F. demonstrated through prevailing peer-reviewed dental literature to be either:

    1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or

    2. safe with promising efficacy

        a. for treating a life threatening dental disease or condition; and

        b. in a clinically controlled research setting; and

        c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Supplement to the EOC. The definition of Necessary used in this EOC relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network - a group of Dentists who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Members. The participation status of providers will change from time to time.

Network Benefits - benefits available for Covered Dental Services when provided by a Dentist who is a Participating Dentist.

Non-Participating Dentist - a Dentist who is not a participant in the Network. If you seek treatment from a Non-Participating Dentist, and have not received prior authorization from the dental plan, you will not be Covered under the dental plan for the services where there was no such prior authorization, except in certain Emergency situations.

Participating Dentist - a Dentist licensed to practice dentistry in the state in which services are being provided, with whom the Company has an agreement for rendering to Subscribers the Dental Services provided by the dental plan.

Physician - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Primary Care Dentist (PCD) - a Participating Dentist providing Covered Dental Services to Members who has been selected by a Member and assigned by Us to provide and arrange for his or her Dental Services.

Procedure in Progress - all treatment for Covered Dental Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Addendum - any attached description of Dental Services Covered under the Group Agreement. Dental Services provided by an Addendum may be subject to payment of additional Premiums and additional Co-payments. Addendums are effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Group Agreement except for those that are specifically amended.

Service Area - the region covered by the Participating Dentists. The exact Service Area for your plan may be obtained from the provider directory.

Specialist Dentist - A Participating Dentist who provides services to a Member within the range of a designated specialty area of practice in which he/she is Board Eligible or Board Certified.

Subscriber - an individual who meets all applicable eligibility requirements described below and enrolls in the dental plan, and for whom prepayment has been received by the dental plan. You may enroll yourself and any eligible Dependents if you meet the dental plan eligibility requirements. To be eligible to enroll as a Subscriber you must be a member of the Employer Group shown on the membership card, and you must enroll within any time limitations established by your Employer Group.

Section 2: When Coverage Ends

Section 2.1 Services in Progress When Coverage Ends

A Member may have Dental Services already in progress when Coverage under this plan ends. Most services that are started but not completed prior to the date Coverage ends will be completed by the PCD under the terms of the plan.

Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Dentures are considered started when the impressions are taken. When one of these services is begun before Coverage ends, the Member may have the service completed for the Member Co-payment identified in the Schedule of Covered Dental Services.

If comprehensive orthodontic treatment is in progress on the date Coverage ends, the Network orthodontist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the Network orthodontist for services after the termination date.

Section 2.2 Extended Coverage

A 30-day temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Member on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a) the end of the 30-day period; or (b.) the date the Member becomes Covered under a succeeding Group Agreement or Group Agreement providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Member while the Group Agreement was in effect, by the attending Dentist; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

Section 3: Reimbursement

Section 3.1 If You Get A Bill

Your Participating Dentist will bill you for services that are not Covered by this dental plan. If you are billed for a Covered Service by your Participating Dentist, and you feel this billing is in error, you should do the following:

1. Call the Participating Dentist to let them know you believe you have received a bill in error.

2. If you are unable to resolve this issue, please contact us at 1-800-228-3384, 1-877-735-2929 (TTY).

Should we pay any fees for services that are the responsibility of the Subscriber, the Subscriber shall reimburse us for such payment. Failure to reimburse us or reach reasonable accommodations with us concerning repayment within 30 days after we request for reimbursement shall be grounds for termination of a Subscriber's membership.

Section 3.2 Your Billing Protection

All our Subscribers have rights that protect them from being charged for Covered Services in the event we fail to pay a Participating Dentist, a Participating Dentist becomes insolvent, or a Participating Dentist breaches its Group Agreement with us. In none of these instances may the Participating Dentist send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Co-payment amounts as outlined in the Schedule of Covered Dental Services.

In the event of a Participating Dentist's insolvency, we will continue to arrange for your benefits. If for any reason we are unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of our insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your Participating Dentist. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Dentist or Emergency services from a Non-Participating Dentist.

NOTE: If you receive a bill because a Non-Participating Dentist refused to accept payment from us, you may submit a claim for reimbursement.

Section 4: Complaint Procedures

Section 4.1 Complaint Resolution

If you have a concern or question regarding the provision of Dental Services or benefits under the Group Agreement, you should contact us at 1-800-228-3384, 1-877-735-2929 (TTY). Customer Service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A Customer Service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If your complaint relates to a claim for payment, your request should include:

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

We will notify you of our decision regarding your complaint within 30 days of receiving it.

Section 4.2 Exceptions for Emergency Situations

Your complaint requires immediate actions when your Dentist judges that a delay in treatment would significantly increase the risk to your health. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dentist should call us as soon as possible.
- We will notify you of the decision by the end of the next business day after your complaint is received, unless more information is needed.
- If we need more information from your Dentist to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments or procedures that we do not consider urgent situations.

Section 4.3 Contacting the California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the number on your ID card and use your health plan s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

Complaint forms, IMR application forms and instructions are available online from the California Department of Managed Care. Contact the DMHC Help Center at the toll-free telephone number (1-888-466-2219) to receive assistance with this process, or submit an inquiry in writing to the DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725 or through the web site: www.dmhc.ca.gov. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-800-735-2929 or 1-888-877-5378 (TTY).

Section 5: General Provisions

Section 5.1 Relationship Between Parties

The relationships between the Company and Participating Dentists are solely contractual relationships between independent contractors. Participating Dentists are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of Participating Dentists.

The relationship between a Participating Dentist and any Member is that of provider and patient. The Participating Dentist is solely responsible for the services provided to any Member.

Section 5.2 Information and Records

At times the Company may need additional information from you. You agree to furnish the Company with all information and proofs that the Company may reasonably require regarding any matters pertaining to the Group Agreement. If you do not provide this information when the Company requests it we may delay or deny payment of your Benefits.

By accepting Benefits under the Group Agreement, you authorize and direct any person or institution that has provided services to you to furnish the Company with all information or copies of records relating to the services provided to you. The Company has the right to request this information at any reasonable time. This applies to all Members whether or not they have signed the Subscriber's enrollment form. The Company agrees that such information and records will be considered confidential.

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

For complete listings of your dental records the Company recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, the Company will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. The Company's designees have the same rights to this information as the Company has.

Section 5.3 Examination of Members

In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Participating Dentist acceptable to the Company examine you at the Company's expense.

The headings, titles and any table of contents contained in the Supplement to the EOC or Schedule of Covered Dental Services are for reference purposes only and shall not in any way affect the meaning or interpretation of the Group Agreement, EOC or Schedule of Covered Dental Services.

Section 5.4 Unenforceable Provisions

If any provision of the Supplement to the EOC or Schedule if Covered Dental Services is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Supplement to the EOC or Schedule of Covered Dental Services to the greatest extent legally permissible.

Section 5.5 Member Rights

During the term of the Group Agreement between us and your Employer Group, we guarantee that it will not decrease any benefits, increase any Co-payment, or change any exclusion or limitation. We will not cancel or fail to renew your enrollment in this plan because of your health condition or your requirements for dental care. Your Participating Dentist is responsible to you for all treatment and services, without interference from us.

However, your Participating Dentist must follow the rules and limitations set up by us and conduct his or her professional relationship with you within the guidelines established by us. If our relationship with your Participating Dentist ends, your dentist is obligated to complete any and all treatment in progress. We will arrange a transfer for you to another dentist to provide for continued coverage under the plan. As indicated on your enrollment form, your signature authorizes us to obtain copies of your dental records, if necessary.

As a member, you have the right to...

- Be treated with respect, dignity and recognition of your need for privacy and confidentiality.
- Express complaints and be informed of the complaint process.
- Have access and availability to care and access to and copies of your dental records.
- Participate in decision-making regarding your course of treatment.
- Be provided information regarding Participating Dentists.
- Be provided information regarding the services, benefits and specialty referral process.

Section 5.6 Member Responsibilities

As a member, you have the responsibility to:

- Identify yourself to your Participating Dentist as a member. If you fail to do so, you may be charged the dentist's usual and customary fees instead of the applicable Co-payment, if any.
- Treat the dentist and his or her office staff with respect and courtesy and cooperate with the prescribed course of treatment. If you continually refuse a prescribed course of treatment, your Participating Dentist or Specialist Dentist has the right to refuse to treat you. We will facilitate second opinions and will permit you to change your Participating Dentist or Specialist Dentist if there is a breakdown in your relationship; however, we will not interfere with the dentist-patient relationship and cannot require a particular dentist to perform particular services.
- Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.
- Make Co-payments at the time of service. If you do not, the dentist may collect those Co-payments from you at subsequent appointments and in accordance with their policies and procedures.
- Notify us of changes in family status. If you do not, we will be unable to authorize dental care for you and/or your family members.
- Be aware of and follow your Employer’s guidelines in seeking dental care. If you do not, your Employer may not have sufficient information to report your eligibility to us, which could result in a denial of care.

Section 5.7 Language Assistance

As a DBPCA member you have a right to free language assistance services, including oral interpretation and, for some documents, translation services in most frequently spoken languages. DBPCA collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform DBPCA of your preferred language, please contact DBPCA at (877) 813-4259 or via our online website at www.myuhc.com.

Como miembro de DBPCA, usted tiene derecho a recibir servicios de ayuda en otros idiomas en forma gratuita, incluyendo interpretación oral y, para ciertos documentos, servicios de traducción en los idiomas que se hablan con más frecuencia. DBPCA recopila y mantiene sus preferencias de idioma, raza y origen étnico para que podamos comunicarnos con más eficacia con nuestros miembros. Si necesita ayuda en otros idiomas o desea informar a DBPCA cuál es su idioma preferido, comuníquese con DBPCA al (877) 813-4259 o a través de nuestro sitio de Internet en línea en www.myuhc.com.

身為 DBPCA 會員，您有權利取得免費語言協助服務，包括多數常用語言的口譯服務及部份文件的書面翻譯服

務。DBPCA 查並記錄您的語言偏好、種族與民族，以增進與會員間溝通的效率。若您需要語言協助或希望將

您的語言偏好通知 DBPCA，請致電 [(877) 813-4259] 與 DBPCA 聯絡，或至網站 www.myuhc.com.

Section 5.8 Non-Covered Services

IMPORTANT: If you opt to receive dental services that are non-covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a Covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost each service. If you would like more information about dental coverage options, you may call member services at (877)813-4259 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

For purposes of this section, “covered services” or “covered dental services” means dental care services for which the plan is obligated to pay pursuant to an enrollee’s dental plan or Group Agreement, or for which the plan would be obligated to pay pursuant to an enrollee’s plan or Group Agreement but for the application of contractual limitations such as deductibles, co-payments, co-insurance, waiting periods, annual or lifetime maximums, frequency limitations or alternative benefit payments.

Section 6: Choice of Providers and Procedures for Obtaining Benefits

Section 6.1 Dental Services

You are eligible for Coverage for Dental Services listed in the Schedule of Covered Dental Services and Section 7: Covered Dental Services of this EOC if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Group Agreement.

Subscribers choose a Dentist from a list of Participating Dentists provided by the dental plan, who will become the Subscriber's "Primary Care Dentist." Your Primary Care Dentist will be the one you call when you need dental advice and when you need preventive care. A Member can also call to determine which providers participate in the Network. The telephone number on the ID card.

Within the Service Area, you are entitled to receive all the Dental Services specified in the Schedule of Covered Dental Services and Section 7: Covered Dental Services of this EOC. You must go to your Participating Dentist for these services unless the dental plan has made prior special arrangements for you. If you do not use a Participating Dentist and the dental plan has not approved the use of a Non-Participating Dentist you will not be Covered for any services received.

Enrolling for Coverage under the Group Agreement does not guarantee Dental Services by a particular Participating Dentist on the list of providers. The list of Participating Dentists is subject to change. When a provider on the list no longer has a Group Agreement with the Company, you must choose among remaining Participating Dentists. You are responsible for verifying the participation status of the Dentist, or other provider prior to receiving such Dental Services. You must show your ID card every time you request Dental Services.

If you fail to verify participation status or to show your ID card, and the failure results in non-compliance with required Company procedures, Coverage may be denied.

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Group Agreement and payment of the Co-payment specified for any service shown in the Schedule of Covered Dental Services and Section 7: Covered Dental Services.

Participating Dentists are responsible for submitting a request for payment directly to the Company, however, a Member is responsible for any Co-payment at the time of service. If a Participating Dentist bills a Member, customer service should be called. A Member does not need to submit claims for Participating Dentist services or supplies.

Section 6.2 Prohibited Referral

The Dental Plan will not make payment of any claim, bill, or other demand or request for payment for dental care services that the appropriate regulatory board determines were provided as a result of a "prohibited referral." Prohibited referral means any referral from a Participating Dentist in which the Participating Dentist owns a beneficial interest; or, in which the Participating Dentist's immediate family owns a beneficial interest of three percent (3%) or greater; or, with which the Participating Dentist, his/her immediate family, or the Participating Dentist in combination with his/her immediate family has a compensation arrangement.

Section 6.3 Missed Appointments

When an appointment is made with a Participating Dentist, you are expected to honor such appointment. If you do not cancel the appointment at least 24 hours in advance, you may be charged a fee for each half-hour segment of the missed appointment for which the Company shall not be liable.

Section 6.4 Selecting a Primary Care Dentist

This plan is designed to provide quality dental care while controlling the cost of this care. Members must seek Dental Services from a Participating Dentist. Except for Emergency Dental Services, in no event will we cover Dental Services provided to a Member by a Non-Participating Dentist. The Network includes Participating Dentists in a Member's geographic area. A "Participating Dentist" is a Dentist that has a provider agreement in force with us. When a Member enrolls in this plan, he or she will get information about our current Participating Dentists. Each Member must select a Primary Care Dentist (PCD) from the list of Participating Dentists who will be responsible for coordinating all of the Member's dental care. We will assign a PCD to the Member. If you have any further questions regarding provider location, office hours or emergency hours or other providers in your area, or to request a copy of the provider directory, you may

contact the telephone number on your ID card to receive that information. You can also find an online version of the directory at www.myuhc.com.

After enrollment, a Member will receive an ID card. A Member can schedule an appointment by simply calling the Dentist and must present this ID card when he or she goes to his or her PCD. All Dental Services Covered by this plan must be coordinated by the Member's PCD whom the Member selects and is assigned to upon enrolling in this plan. Please read your materials carefully for specific benefit levels, exclusions, Coverage limits and Member Co-payments. You can call the telephone number on your ID card if you have any questions after reading your materials.

We compensate our Participating Dentists on a fixed prepayment fee each month based upon the number of Members that select the Dentist as their PCD. The Dentist may also receive supplemental payments from us for select procedures. The Dentist also receives compensation from Members who pay a defined patient Co-payment for specific Dental Services. The schedule of Member Co-payments is shown in the Schedule of Covered Dental Services.

Section 6.5 Changing Your Primary Care Dentist

You may transfer to another Primary Care Dentist (PCD) if you have no Procedure in Progress. All Procedures in Progress started at your current PCD should be completed before a change, unless a quality-of-care issue is identified. If you wish to select another Dentist, you may contact the telephone number on your ID card. If you elect to change offices without completing Procedures In Progress, you may be responsible for all billed charges by your new PCD. If you owe your PCD any money, you will be asked to settle your account at the time you transfer.

We review transfer requests on a case-by-case basis. If you meet the above requirements and call us by the 20th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 20th of the current month, your transfer will be effective the first day of the second succeeding month. For example, if you meet the above requirements and you call us on June 17th to request a new PCD, the transfer will be effective on July 1st. If you meet the above requirements and you call us on June 21st, the transfer will be effective August 1st.

A provider is required to copy and deliver your complete patient file upon your request. A provider may charge you a reasonable fee for the copying and delivery of your records.

If a Network Provider is not available within a reasonable distance from your primary residence or primary workplace, you will be referred by us to a Non-Participating Dentist and instructed on reimbursement procedures for service costs in excess of plan Co-payments. For reimbursement procedure information, please contact the telephone number on your ID card.

Section 6.6 Changes in Dentist Participation

If: (a) the Dentist you selected is no longer a Participating Dentist in the Network; or (b) if we take an administrative action which affects the Dentist's participation in the Network, we may have to enroll you with a different Participating Dentist. If this occurs, you will have the opportunity to choose another Participating Dentist from among those in the Network. If you have a Dental Procedure in Progress when reassignment becomes necessary, we will, at your option and subject to applicable law, either: (a) arrange for completion of the services by the original PCD, if he or she agrees: (i) to accept payment at the Group Agreement fee; and (ii) to abide by all plan provisions; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service. We will send you written notice when we are aware that a Participating Dentist is no longer available to treat you.

When we change your Participating Dentist: Under special circumstances we may require that a Subscriber change his or her Participating Dentist. Generally, this happens at the request of the Participating Dentist after a material detrimental change in their relationship with a Subscriber. If this occurs, we will notify the Subscriber of the effective date of the change and we will transfer the Subscriber to another Participating Dentist, provided he or she is medically able and there is an alternative Participating Dentist.

Section 6.7 Emergency Dental Services

All contracted Primary Care Dentists (PCD) provide Emergency Dental Services twenty-four (24) hours a day, seven (7) days a week. You may contact your PCD, who will make arrangements for Emergency care.

If you are unable to reach your PCD in an Emergency during normal business hours, you may call our customer service department for instructions.

If you are unable to reach your PCD in an Emergency after normal business hours, you may seek Emergency Dental Services from any licensed Dentist. Then, within 2 business days, you may call our customer service department to notify us of the Emergency claim.

Out of Area Emergency Dental Services

If you are more than 50 miles from your home or Primary Care Dentist and Emergency Dental Services are required, you may seek care from any licensed Dentist. We will reimburse you for Covered Emergency Dental Services for emergency relief of pain only, up to a maximum of $50 of your co-payment per incident, subject to applicable Co-payments.

Claims for Emergency Dental Services

To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within 90 days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were Necessary. We will provide reimbursement within 30 days of receipt. We will reimburse you for the cost of the Emergency Dental Services, less any Co-payment which may apply.

All reimbursement requests should be mailed to:

Dental Benefit Providers of California, Inc.

P.O. Box 30567

Salt Lake City, Utah 84130-0567

Section 6.8 Specialty Referrals

Your Primary Care Dentist (PCD) is responsible for providing all Covered Dental Services. But, certain services may be eligible for referral to a Network Specialist Dentist. Specialty care will be Covered, less any applicable Co-payment, when such specialty services are provided in accordance with the specialty referral process described below.

We compensate our Network Specialist Dentist the difference between their Group Agreement fee and the Co-payment shown in the Schedule of Covered Dental Services. This is the only form of compensation that Network Specialists receive from us.

All Specialty Referral Services Must Be: (A) Pre-Authorized by us; and (B) Coordinated by a Member's PCD. Any Member who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred.

In order for specialty services to be Covered by this plan, the following referral process must be followed:

1. A Member's PCD must coordinate all Dental Services.
2. When the care of a Network Specialist Dentist is required, the Member's PCD must contact us and request authorization.
3. If the PCD's request for specialist referral is approved, we will notify the Member. He or she will be instructed to contact the Network Specialist Dentist to schedule an appointment.
4. If the PCD's request for specialist referral is denied, the PCD and the Member will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
5. A Member who receives authorized specialty services must pay all applicable Co-payments associated with the services provided. When we authorize specialty dental care, a Member will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Member's Service Area. If there is no Network Specialist Dentist in the Member's Service Area, we will refer the Member to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Member by a specialist not pre-authorized by us to provide such services.

Section 6.9 Second Opinion Consultation

A Member, or his or her treating PCD, may submit a request for a second dental opinion to us by writing or calling the telephone number on your ID card. Referrals to a Provider for second dental opinions will be provided when requested. All requests for a second opinion are processed within five (5) business days of receipt by us of such request. The requesting

Network Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within 2 business days.

Second dental opinions will be rendered by an appropriately qualified dental professional. An appropriately qualified dental professional is a licensed health care dental Provider who is acting within his or her scope of practice and who

possesses the clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second dental opinion.

If the Member is requesting a second dental opinion about care received from his or her PCD, the second dental opinion will be provided by an appropriately qualified health care professional within the Network. If the Member is requesting a second dental opinion about care received from a Specialist Dentist, the second dental opinion will be provided by a Specialist within the Network of the same or equivalent specialty.

The plan's benefit for a second opinion consultation is limited to $50. If a Participating Dentist is the consultant, there is no cost to the Member. If a Non-Participating Dentist is the consultant, the Member must pay any portion of his or her fee over $50.

Section 7: Covered Dental Services

Dental Services described in this Section and in the Schedule of Covered Dental Services are covered when such services are Necessary and not excluded as described in Section 8: General Exclusions.

Covered Dental Services are subject to satisfaction of the payment of any Co-payments as described below and in the Schedule of Covered Dental Services.

Covered Dental Services must be provided by or directed by a Participating Dentist.

This Section and the Schedule of Covered Dental Services: (1) describe the Covered Dental Services and any applicable limitations to those services; (2) outline the Co-payments that you are required to pay for each Covered Dental Service; and (3) describe any Maximum Benefits that may apply.

Section 7.1 Medically Necessary Orthodontics

MEDICALLY NECESSARY ORTHODONTICS

Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.

Section 7.2 Additional Provisions

Non-Covered and Alternative Procedures

More than one procedure may be appropriate for treating a dental condition. A Member may choose an appropriate alternative procedure over the service the PCD recommended. If the alternative procedure is Covered under the plan, the Member pays the Co-payment for that procedure. If the alternative procedure is not Covered under the plan, the PCD may charge his or her usual and customary charges for the non-Covered service.

Whenever there is more than one course of treatment available, a full disclosure of all the options must be given to the Member before any treatment begins. When non-Covered services are part of a Member's treatment plan, the Dentist should present the Member with a treatment plan in writing before treatment begins, to assure that there is no confusion over what the Member will be required to pay.

Multiple Crown/Bridge Unit Treatment Fee

A Member's recommended treatment plan may include 7 or more Covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the Member must pay both: (a) the usual crown or bridge patient charge for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Schedule of Covered Dental Services. The maximum benefit within a 12-month period is for 7 crowns or pontics.

Section 7.3 Schedule of Covered Dental Services

SCHEDULE OF COVERED DENTAL SERVICES

Out-of-Pocket Limit -Any amount you pay in Co-payments for pediatric Dental Services under this Addendum applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
DIAGNOSTIC SERVICES ***(Not subject to payment of the Annual Deductible.)***		
D0120	Periodic Oral Evaluation - Established Patient ▪ Limited to once every 6 months	No charge
D0140	Limited Oral Evaluation - Problem Focused ▪ Limited to once per patient	No charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver • Limited to once every 6 months	No charge
D0150	Comprehensive Oral Evaluation – new or established patient ▪ Limited to once per patient for an initial evaluation	No charge
D0160	Detailed and Extensive Oral Evaluation - Problem-Focused, by report ▪ Limited to once per patient	No charge
D0170	Re-Evaluation, Limited, Problem Focused (established patient; not post-operative visit) ▪ Limited to 6 times in a 3 month period ▪ Limited to a maximum of 12 in a 12-month period	No charge
D0171	Re-evaluation - post operative office visit ▪ Limited to 6 times in a 3 month period ▪ Limited to a maximum of 12 in a 12-month period	No charge
D0180	Comprehensive periodontal evaluation - new or established patient ▪ Limited to once per patient for an initial evaluation	No charge
D0210	Intraoral - Complete Series of Radiographic Images ▪ Limited to once every 36 months	No charge
D0220	Intraoral - Periapical - First Radiographic Image ▪ Limited to a maximum of 20 periapicals in a 12-month period	No charge
D0230	Intraoral - Periapical - Each Additional Radiographic Image ▪ Limited to a maximum of 20 periapicals in a 12-month period	No charge
D0240	Intraoral - Occlusal Radiographic Image ▪ Limited to a maximum of 2 in a 6-month period	No charge

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source and detector ▪ Limited to once per date of service	No charge
D0251	Extraoral posterior dental radiographic image ▪ Limited to once per date of service	No charge
D0270	Bitewing – Single Radiographic Image ▪ Limited to once per date of service	No charge
D0272	Bitewings - Two Radiographic Images ▪ Limited to once every 6 months	No charge
D0273	Bitewings - Three Radiographic Images ▪ Limited to once every 6 months	No charge
D0274	Bitewings - Four Radiographic Images ▪ Limited to once every 6 months	No charge
D0277	Vertical Bitewings – 7 to 8 Radiographic Images ▪ Limited to once every 6 months	No charge
D0310	Sialography	No charge
D0320	Temporomandibular Joint Arthrogram, including Injection ▪ Limited to a maximum of 3 per date of service	No charge
D0322	Tomographic Survey ▪ Limited to twice in a 12-month period	No charge
D0330	Panoramic Radiographic Image ▪ Limited to once in a 36-month period	No charge
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis ▪ Limited to twice in a 12-month period	No charge
D0350	2D oral/ facial photographic image obtained intra-orally or extra-orally ▪ Limited to a maximum of 4 per date of service	No charge
D0351	3D photographic image ▪ When medically necessary	No charge
D0419	Assessment of salivary flow by measurement	No charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	No charge
D0460	Pulp vitality tests	No charge

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D0470	Diagnostic Casts ▪ Limited to once per provider	No charge
D0502	Other oral pathology procedures, by report	No charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge
D0701	Panoramic radiographic image – image capture only	No charge
D0702	2-D cephalometric radiographic image – image capture only	No charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	No charge
D0704	3-D photographic image – capture only	No charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No charge
D0706	Intraoral - occlusal radiographic image – image capture only	No charge
D0707	Intraoral - periapical radiographic image – image capture only	No charge
D0708	Intraoral - bitewing radiographic image – image capture only	No charge
D0709	Intraoral – complete series of radiographic images – image capture only	No charge
D9311	Consultation with a medical health care professional	No charge
D0999	Unspecified diagnostic procedure, by report	No charge
PREVENTIVE SERVICES *(Not subject to payment of the Annual Deductible.)*		
D1110	Prophylaxis – adult ▪ Limited to once in a 12-month period	No charge
D1120	Prophylaxis – child ▪ Limited to once in a 6-month period	No charge
D1206	Topical application of fluoride varnish ▪ Limited to once in a 6-month period	No charge
D1208	Topical application of fluoride ▪ Limited to once in a 6-month period	No charge
D1310	Nutritional counseling for control of dental disease ▪ Covered in conjunction with your Periodic Oral Evaluation	No charge
D1320	Tobacco counseling for the control and prevention of oral disease ▪ Covered in conjunction with your Periodic Oral Evaluation	No charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.	No charge

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D1330	Oral hygiene instructions ▪ Covered in conjunction with your Periodic Oral Evaluation	No charge
D1351	Sealant - Per Tooth ▪ Limited to once per tooth every 36 months regardless of surfaces sealed	No charge
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk patient – Permanent Tooth ▪ Limited to once per tooth every 36 months regardless of surfaces sealed	No charge
D1353	Sealant repair - Per Tooth	No charge
D1354	Interim caries arresting medicament application - per tooth	No charge
D1355	Caries preventive medicament application - per tooth	No charge
D1510	Space maintainer - Fixed – Unilateral ▪ Limited to 1 per quadrant per patient	No charge
D1516	Space maintainer - Fixed – Bilateral, Maxillary	No charge
D1517	Space maintainer - Fixed – Bilateral, Mandibular	No charge
D1520	Space maintainer - removable – unilateral • Limited to 1 per quadrant per patient	No charge
D1526	Space maintainer - removable - bilateral, maxillary	No charge
D1527	Space maintainer – removable – bilateral, mandibular	No charge
D1551	Re-cement or re-bond bilateral space maintainer – maxillary ▪ Limited to once per applicable quadrant or arch	No charge
D1552	Re-cement or re-bond bilateral space maintainer – mandibular ▪ Limited to once per applicable quadrant or arch	No charge
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant ▪ Limited to once per applicable quadrant or arch	No charge
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge
D1575	Distal shoe space maintainer - fixed – unilateral ▪ Limited to once per quadrant per patient	No charge

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
RESTORATIVE SERVICES ***(Not subject to payment of the Annual Deductible.)***		
D2140	Amalgam - One Surface, Primary or Permanent ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$25
D2150	Amalgam - Two Surfaces, Primary or Permanent ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$30
D2160	Amalgam - Three Surfaces, Primary or Permanent ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$40
D2161	Amalgam - Four or More Surfaces, Primary or Permanent ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$45
D2330	Resin-Based Composite - One Surface, Anterior\ ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$30
D2331	Resin-Based Composite - Two Surfaces, Anterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$45
D2332	Resin-Based Composite - Three Surfaces, Anterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$55

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior) ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$60
D2390	Resin-Based Composite Crown, Anterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$50
D2391	Resin-Based Composite - One Surface, Posterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$30
D2392	Resin-Based Composite - Two Surfaces, Posterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$40
D2393	Resin-Based Composite - Three Surfaces, Posterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$50
D2394	Resin-Based Composite - Four or More Surfaces, Posterior ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$70
D2710	Crown - Resin-Based Composite (indirect) ▪ Limited to once in a 5-year period	$140
D2712	Crown - 3/4 Resin-Based Composite (indirect) ▪ Limited to once in a 5-year period	$190

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D2721	Crown - Resin with Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D2740	Crown - Porcelain/Ceramic Substrate ▪ Limited to once in a 5-year period	$300
D2751	Crown - Porcelain Fused to Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D2781	Crown - 3/4 Cast Predominately Base Metal ▪ Limited to once in a 5-year period	$300
D2783	Crown - 3/4 Porcelain/Ceramic ▪ Limited to once in a 5-year period	$310
D2791	Crown - Full Cast Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D2910	Recement Inlay, Onlay or Partial Coverage Restoration ▪ Limited to once in a 12-month period	$25
D2915	Recement cast or prefabricated post and core ▪ Not covered if preformed within 12 months of a previous re-cementation by the same provider	$25
D2920	Recement Crown ▪ Not covered if preformed within 12 months of a previous re-cementation by the same provider	$25
D2921	Reattachment of tooth fragment – incisal edge or cusp	$45
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$95
D2930	Prefabricated Stainless Steel Crown - Primary Tooth ▪ Limited to once in 12-month period	$65
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth ▪ Limited to once in a 36-month period	$75
D2932	Prefabricated Resin Crown ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$75

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D2933	Prefabricated Stainless Steel Crown with Resin Window ▪ Primary Teeth: Limited to once in a 12-month period ▪ Permanent Teeth: Limited to once in a 36-month period	$80
D2940	Protective Restoration ▪ Limited to once per tooth in a 6-month period	$25
D2941	Interim therapeutic restoration - primary dentition ▪ Limited to once per tooth regardless of the number of pins placed	$30
D2949	Restorative foundation for an indirect restoration ▪ Limited to once per tooth regardless of the number of pins placed	$45
D2950	Core buildup, including any pins ▪ Limited to once per tooth regardless of the number of pins placed	$20
D2951	Pin Retention - Per Tooth, in addition to Restoration ▪ Limited to once per tooth regardless of the number of pins placed	$25
D2952	Post and Core in addition to Crown, indirectly fabricated ▪ Limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post – same ▪ Limited to once per tooth regardless of the number of pins placed	$30
D2954	Prefabricated Post and Core in addition to Crown ▪ Limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal ▪ Limited to once per tooth regardless of the number of pins placed	$60
D2957	Each additional prefabricated post – same tooth ▪ Limited to once per tooth regardless of the number of pins placed	$35
D2971	Additional procedures to customize a crown under an existing partial denture framework ▪ Limited to once per tooth regardless of the number of pins placed	$35
D2980	Crown repair necessitated by Restorative material failure	$50
D2999	Unspecified restorative procedure, by report	$40

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
ENDODONTICS ***(Not subject to payment of the Annual Deductible.)***		
D3110	Pulp cap – direct (excluding final restoration) ▪ Limited to once per primary tooth	$20
D3120	Pulp cap – indirect (excluding final restoration) ▪ Limited to once per primary tooth	$25
D3220	Therapeutic Pulpotomy (excluding final restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and application of Medicament ▪ Limited to once per primary tooth	$40
D3221	Pulpal Debridement, Primary and Permanent Teeth ▪ Limited to once per tooth	$40
D3222	Partial Pulpotomy for Apexogenesis - Permanent Tooth with Incomplete Root Development ▪ Limited to once per permanent tooth	$60
D3230	Pulpal Therapy (resorbable filling) - Anterior, Primary Tooth (excluding final restoration) ▪ Limited to once per permanent tooth	$55
D3240	Pulpal Therapy (resorbable filling) - Posterior, Primary Tooth (excluding final restoration) ▪ Limited to once per permanent tooth	$55
D3310	Endodontic Therapy, Anterior tooth (excluding final restoration) ▪ Limited to once per tooth for initial root canal therapy treatment	$195
D3320	Endodontic Therapy– Bicuspid tooth (excluding final restoration) ▪ Limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic Therapy – Molar tooth (excluding final restoration) ▪ Limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access ▪ Limited to once per tooth for initial root canal therapy treatment	$50
D3333	Internal root repair of perforation defects ▪ Limited to once per tooth for initial root canal therapy treatment	$80
D3346	Retreatment of Previous Root Canal Therapy – Anterior ▪ Not covered if preformed within 12 months from initial treatment by the original provider	$240
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid ▪ Not covered if preformed within 12 months from initial treatment by the original provider	$295

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D3348	Retreatment of Previous Root Canal Therapy – Molar ▪ Not covered if preformed within 12 months from initial treatment by the original provider ▪ Not covered for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests	$365
D3351	Apexification/Recalcification/Pulpal Regeneration - Initial Visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) ▪ Limited to once per permanent tooth	$85
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement (following apexification/ recalcification – initial visit) ▪ Limited to once per permanent tooth	$45
D3410	Apicoectomy/Periradicular Surgery – Anterior ▪ Not covered if preformed within 90 days from root canal therapy unless medically necessary ▪ Not covered if preformed within 24 months of a prior apicoectomy/periradicular surgery	$240
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root) ▪ Not covered if preformed within 90 days from root canal therapy unless medically necessary ▪ Not covered if preformed within 24 months of a prior apicoectomy/ periradicular surgery, same root	$250
D3425	Apicoectomy/Periradicular Surgery - Molar (first root) ▪ Not covered if preformed within 90 days from root canal therapy unless medically necessary ▪ Not covered if preformed within 24 months of a prior apicoectomy/periradicular surgery, same root ▪ Not covered for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests	$275
D3426	Apicoectomy/Periradicular Surgery (each additional root) ▪ Not covered if preformed within 90 days from root canal therapy unless medically necessary ▪ Not covered if preformed within 24 months of a prior apicoectomy/ periradicular surgery, same root ▪ Not covered for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests	$110

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D3430	Retrograde filing – per root ▪ Limited to once per tooth for initial root canal therapy treatment	$90
D3471	Surgical repair of root restoration - anterior	$160
D3472	Surgical repair of root restoration - premolar	$160
D3473	Surgical repair of root restoration - molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam ▪ Limited to once per tooth for initial root canal therapy treatment	$30
D3999	Unspecified endodontic procedure, by report ▪ Limited to once per tooth for initial root canal therapy treatment	$100
PERIODONTICS *(Not subject to payment of the Annual Deductible.)*		
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant ▪ Limited to once per quadrant every 36 months	$150
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant ▪ Limited to once per quadrant every 36 months	$50
D4249	Clinical crown Lengthening – hard tissue ▪ Limited to once per quadrant every 36 months	$165
D4260	Osseous Surgery (including flap entry and closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant ▪ Limited to once per quadrant every 36 months	$265
D4261	Osseous Surgery (including flap entry and closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant ▪ Limited to once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site ▪ Limited to once per quadrant every 36 months	$80
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant ▪ Limited to once per quadrant every 24 months	$55
D4342	Periodontal Scaling and Root Planing - One - Three Teeth Per Quadrant ▪ Limited to once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation ▪ Limited to once per quadrant every 24 months	$40
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis ▪ Limited to once per quadrant every 36 months	$40

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal Maintenance ▪ Limited to once in a calendar quarter	$30
D4920	Unscheduled Dressing Change (by someone other than treating Dentist) ▪ Limited to once per patient	$15
D4999	Unspecified periodontal procedure, by report	$350
PROSTHODONTICS, REMOVABLE *(Not subject to payment of the Annual Deductible.)*		
D5110	Complete Denture – Maxillary ▪ Limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	$300
D5120	Complete Denture – Mandibular ▪ Limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	$300
D5130	Immediate Denture – Maxillary ▪ Limited to once per patient	$300
D5140	Immediate Denture – Mandibular ▪ Limited to once per patient	$300
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth) ▪ Limited to once in a 5-year period	$300
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth) ▪ Limited to once in a 5-year period	$300
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including retentive/clasping materials, rests and teeth) ▪ Limited to once in a 5-year period	$335
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including retentive/clasping materials, rests and teeth) ▪ Limited to once in a 5-year period	$335
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D5410	Adjust Complete Denture – Maxillary ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$20
D5411	Adjust Complete Denture – Mandibular ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$20
D5421	Adjust Partial Denture - Maxillary ▪ Limited to once per date of service ▪ Limited to twice in a 12 month period	$20
D5422	Adjust Partial Denture – Mandibular ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$20
D5511	Repair broken complete denture base, mandibular ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$40
D5512	Repair broken complete denture base, maxillary ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$40
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth) ▪ Limited to a maximum of 4, per arch, per date of service ▪ Limited to twice per arch, in a 12-month period	$40
D5611	Repair resin partial denture base, mandibular ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$40
D5612	Repair resin partial denture base, maxillary ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$40
D5621	Repair cast partial framework, mandibular ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$40
D5622	Repair cast partial framework, maxillary ▪ Limited to once per date of service ▪ Limited to twice in a 12-month period	$40

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D5630	Repair or Replace Broken Clasp ▪ Limited to a maximum of 3, per date of service ▪ Limited to twice per arch, in a 12-month period	$50
D5640	Replace Broken Teeth - Per Tooth ▪ Limited to a maximum of 4, per arch, per date of service ▪ Limited to twice per arch, in a 12-month period	$35
D5650	Add Tooth to Existing Partial Denture ▪ Limited to a maximum of 3, per date of service ▪ Limited to once per tooth	$35
D5660	Add Clasp to Existing Partial Denture - per tooth ▪ Limited to a maximum of 3, per date of service ▪ Limited to twice per arch, in a 12-month period	$60
D5730	Reline Complete Maxillary Denture (Chairside) ▪ Limited to once in a 12-month period	$60
D5731	Reline Complete Mandibular Denture (Chairside) ▪ Limited to once in a 12-month period	$60
D5740	Reline Maxillary Partial Denture (Chairside) ▪ Limited to once in a 12-month period	$60
D5741	Reline Mandibular Partial Denture (Chairside) ▪ Limited to once in a 12-month period	$60
D5750	Reline Complete Maxillary Denture (Laboratory) ▪ Limited to once in a 12-month period	$90
D5751	Reline Complete Mandibular Denture Laboratory) ▪ Limited to once in a 12-month period	$90
D5760	Reline Maxillary Partial Denture (Laboratory) ▪ Limited to once in a 12-month period	$80
D5761	Reline Mandibular Partial Denture (Laboratory) ▪ Limited to once in a 12-month period	$80
D5850	Tissue Conditioning, Maxillary ▪ Limited to twice per prosthesis in a 36-month period	$30
D5851	Tissue Conditioning, Mandibular ▪ Limited to twice per prosthesis in a 36-month period	$30
D5862	Precision attachment, by report ▪ Limited to once in a 5-year period	$90

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	CO-PAYMENT *(The Amount You Pay)*
D5863	Overdenture – Complete Maxillary ▪ Limited to once in a 5-year period	$300
D5864	Overdenture - Partial Maxillary ▪ Limited to once in a 5-year period	$300
D5865	Overdenture – Complete Mandibular ▪ Limited to once in a 5-year period	$300
D5866	Overdenture – Partial Mandibular ▪ Limited to once in a 5-year period	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
MAXILLOFACIAL PROSTHETICS *(Not Subject to payment of the Annual Deductible)* The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. Covered when medically necessary		
D5911	Facial moulage (sectional) ▪ Covered when medically necessary	$285
D5912	Facial moulage (complete) ▪ Covered when medically necessary	$350

D5913	Nasal prosthesis ▪ Covered when medically necessary	$350
D5914	Auricular prosthesis ▪ Covered when medically necessary	$350
D5915	Orbital prosthesis ▪ Covered when medically necessary	$350
D5916	Ocular prosthesis ▪ Covered when medically necessary	$350
D5919	Facial prosthesis ▪ Covered when medically necessary	$350
D5922	Nasal septal prosthesis ▪ Covered when medically necessary	$350
D5923	Ocular prosthesis, interim ▪ Covered when medically necessary	$350
D5924	Cranial prosthesis ▪ Covered when medically necessary	$350
D5925	Facial augmentation implant prosthesis ▪ Covered when medically necessary	$200
D5926	Nasal prosthesis, replacement ▪ Covered when medically necessary	$200
D5927	Auricular prosthesis, replacement ▪ Covered when medically necessary	$200
D5928	Orbital prosthesis, replacement ▪ Covered when medically necessary	$200
D5929	Facial prosthesis, replacement ▪ Covered when medically necessary	$200
D5931	Obturator prosthesis, surgical ▪ Covered when medically necessary	$350
D5932	Obturator prosthesis, definitive ▪ Covered when medically necessary	$350
D5933	Obturator prosthesis, modification ▪ Covered when medically necessary	$150
D5934	Mandibular resection prosthesis with guide flange ▪ Covered when medically necessary	$350
D5935	Mandibular resection prosthesis without guide flange ▪ Covered when medically necessary	$350

D5936	Obturator prosthesis, interim ▪ Covered when medically necessary	$350
D5937	Trismus appliance (not for TMD treatment) ▪ Covered when medically necessary	$85
D5951	Feeding aid ▪ Covered when medically necessary	$135
D5952	Speech aid prosthesis, pediatric ▪ Covered when medically necessary	$350
D5953	Speech aid prosthesis, adult ▪ Covered when medically necessary	$350
D5954	Palatial augmentation prosthesis ▪ Covered when medically necessary	$135
D5955	Palatial lift prosthesis, definitive ▪ Covered when medically necessary	$350
D5958	Palatial lift prosthesis, interim ▪ Covered when medically necessary	$350
D5959	Palatial lift prosthesis, modification ▪ Covered when medically necessary	$145
D5960	Speech aid prosthesis, modification ▪ Covered when medically necessary	$145
D5982	Surgical stent ▪ Covered when medically necessary	$70
D5983	Radiation carrier ▪ Covered when medically necessary	$55
D5984	Radiation shield ▪ Covered when medically necessary	$85
D5985	Radiation cone locator ▪ Covered when medically necessary	$135
D5986	Fluoride gel carrier ▪ Covered when medically necessary	$35
D5987	Commissure splint ▪ Covered when medically necessary	$85
D5988	Surgical splint ▪ Covered when medically necessary	$95
D5991	Vesiculobullous disease medicament carrier ▪ Covered when medically necessary	$70

D5999	Unspecified maxillofacial prosthesis, by report ▪ Covered when medically necessary	$350
IMPLANTS ***(Not subject to payment of the Annual Deductible.)***		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Second stage implant surgery	$350
D6013	Surgical placement of mini implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6052	Semi-precision attachment abutment	$350
D6055	Connecting bar – implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominately base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominately base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported crown – porcelain fused to high alloys	$335
D6067	Implant supported crown – high noble alloys	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for porcelain cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)	$290
D6074	Abutment supported retainer for porcelain cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330

D6077	Implant supported retainer for metal FPD - high noble alloys	$350
D6080	Implant maintenance procedures including removal of prosthesis, cleansing of prostheses and abutments and reinsertion of prosthesis	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown porcelain fused to noble alloys	$335
D6084	Implant supported crown porcelain fused to titanium and titanium alloys	$335
D6085	Provisional implant crown	$300
D6086	Implant supported crown - predominantly base alloys	$340
D6087	Implant supported crown – noble alloys	$340
D6088	Implant supported crown – titanium and titanium alloys	$340
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/ abutment supported crown ▪ Not covered within the 12 months of previous recementation by the same provider	$25
D6093	Recement implant/abutment supported fixed partial denture ▪ Not covered within the 12 months of previous recementation by the same provider	$35
D6094	Abutment supported crown – titanium and titanium alloys	$295
D6095	Repair implant abutment, by report	$65
D6096	Remove broken implant retaining screw	$60
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$110
D6110	Implant/Abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/Abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350

D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$330
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD – noble alloys	$350
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$350
D6190	Radiographic/surgical implant index, by report	$75
D6191	Semi-precision abutment – placement	$350
D6192	Semi-precision attachment – placement	$350
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6199	Unspecified implant procedure, by report ▪ Limited to once in a 5-year period	$350
PROSTHODONTICS, FIXED ***(Not subject to payment of the Annual Deductible.)***		
D6211	Pontic - Cast Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D6241	Pontic - Porcelain Fused to Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D6245	Pontic - Porcelain/Ceramic ▪ Limited to once in a 5-year period	$300
D6251	Pontic - Resin with Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D6721	Crown - Resin with Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D6740	Crown - Porcelain/Ceramic ▪ Limited to once in a 5-year period	$300
D6751	Crown - Porcelain Fused to Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D6781	Crown - 3/4 Porcelain/Ceramic Predominantly Base Metal • Limited to once in a 5-year period	$300
D6783	Crown - 3/4 Porcelain/Ceramic ▪ Limited to once in a 5-year period	$300

D6784	Crown - 3/4 Titanium and titanium alloys ▪ Limited to once in a 5-year period	$300
D6791	Crown - Full Cast Predominantly Base Metal ▪ Limited to once in a 5-year period	$300
D6930	Recement Fixed Partial Denture ▪ Not covered within the 12 months of a previous recommendation by the same provider	$40
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure ▪ Not covered within the 12 months of initial placement or previous repair, same provider	$95
D6999	Unspecified fixed prosthodontic procedure, by report ▪ Limited to once in a 5-year period	$350
ORAL SURGERY ***(Not subject to payment of the Annual Deductible.)***		
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$40
D7140	Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal) ▪ Not covered if performed by the same provider who performed the initial tooth extraction	$65
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	$120
D7220	Removal of Impacted Tooth - Soft Tissue	$95
D7230	Removal of Impacted Tooth - Partially Bony	$145
D7240	Removal of Impacted Tooth - Completely Bony	$160
D7241	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$175
D7250	Surgical Removal of Residual Tooth Roots (cutting procedure) ▪ Not covered if performed by the same provider who performed the initial tooth extraction	$80
D7260	Oral Antral Fistula Closure ▪ Not covered in conjunction with extraction procedures	$280
D7261	Primary closure of a sinus perforation ▪ Covered when medically necessary and performed in a dental setting	$285
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth ▪ Limited to one per arch regardless of the number of teeth involved	$185
D7280	Exposure of an Unerupted Tooth ▪ Not covered for 3rd molars	$220

D7283	Placement of device to facilitate eruption of impacted tooth ▪ Not covered for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position	$85
D7285	Incisional Biopsy of Oral Tissue - Hard (bone, tooth) ▪ Limited to once per arch, per date of service regardless of the areas involved	$180
D7286	Incisional Biopsy of Oral Tissue - Soft ▪ Limited to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth ▪ Limited to once per arch	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy by report ▪ Limited to once per arch	$80
D7310	Alveoloplasty In Conjunction With Extractions – four or more teeth or tooth spaces, per quadrant ▪ Not covered when only one tooth is extracted in the same quadrant on the same date of service	$85
D7311	Alveoplasty In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant	$50
D7320	Alveoloplasty Not In Conjunction With Extractions - Four or more teeth spaces, Per Quadrant ▪ Not covered within 6 months following extractions in the same quadrant, for the same provider	$120
D7321	Alveoplasty Not In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) ▪ Limited to once in a 5-year period per arch	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of the soft tissue attachment and management of hypertrophied and hyperplastic tissue) ▪ Limited to once per arch	$350
D7410	Excision of Benign Lesion up to 1.25 Cm	$75
D7411	Excision of Benign Lesion greater than 1.25 cm	$115
D7412	Excision of Benign Lesion – Complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$95

D7414	Excision of malignant lesion greater than 1.25 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$120
D7415	Excision of malignant lesion, complicated ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$185
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 cm	$180
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 cm	$330
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm	$155
D7461	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 cm	$250
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by report	$40
D7471	Removal of Lateral Exostosis (Maxilla or Mandible) ▪ Limited to once per quadrant	$140
D7472	Removal of Torus Palatinus ▪ Limited to once per lifetime of patient	$145
D7473	Removal of Torus Mandibularis ▪ Limited to once per quadrant	$140
D7485	Surgical Reduction of Osseous Tuberosity ▪ Limited to once per quadrant	$105
D7490	Radical Resection of Maxilla or Mandible	$350
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue ▪ Limited to once per quadrant, same date of service	$70

D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (includes drainage of multiple fascial spaces) ▪ Limited to once per quadrant, same date of service	$70
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	$70
D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue - Complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue. ▪ Limited to once per date of service	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system ▪ Limited to once per date of service	$75
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone ▪ Limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$250
D7630	Mandible - open reduction (teeth immobilized, if present) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7640	Mandible - closed reduction (teeth immobilized, if present) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7650	Malar and/ or zygomatic arch - open reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350

D7660	Malar and/ or zygomatic arch - closed reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7670	Alveolus - closed reduction, may include stabilization of teeth ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$170
D7671	Alveolus - open reduction, may include stabilization of teeth ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$230
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7710	Maxilla – open reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$110
D7720	Maxilla – closed reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$180
D7730	Mandible – open reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7740	Mandible – closed reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$290

D7750	Malar and/ or zygomatic arch – open reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$220
D7760	Malar and/ or zygomatic arch – closed reduction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7770	Alveolus – open reduction stabilization of teeth ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$135
D7771	Alveolus – closed reduction stabilization of teeth ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7810	Open reduction of dislocation ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7820	Closed reduction of dislocation ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$80
D7830	Manipulation under anesthesia ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$85

D7840	Condylectomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7850	Surgical discectomy, with/ without implant ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7852	Disc repair ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7854	Synovectomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7856	Myotomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7858	Joint reconstruction ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7860	Arthrostomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7865	Arthroplasty ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350

D7870	Arthrocentesis ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$90
D7871	Non-arthroscopic lysis and lavage ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$150
D7872	Arthroscopy – diagnosis, with or without biopsy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7874	Arthroscopy – surgical: disc repositioning and stabilization ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7875	Arthroscopy – surgical: synovestomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7876	Arthroscopy – surgical: discectomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7877	Arthroscopy – surgical: debridement ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350

D7880	Occlusal orthotic device, by report ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$120
D7881	Occlusal orthotic device, by adjustment	$30
D7899	Unspecified TMD therapy, by report ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7910	Suture of recent small wounds up to 5 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$35
D7911	Complicated suture – up to 5 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$55
D7912	Complicated suture – greater than 5 cm ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$130
D7920	Skin graft (identify defect covered, location and type of graft) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7940	Osteoplasty – for Orthognathic deformities ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$160

D7941	Osteotomy – mandibular rami ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7944	Osteotomy – segmented or subapical ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$275
D7945	Osteotomy – body of mandible ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7946	LeFort I (maxilla – total) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7947	LeFort I (maxilla – segmented) ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7949	LeFort II or LeFort III – without bone graft ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350

D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$290
D7952	Sinus augmentation with bone or bone substitute via a vertical approach ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$175
D7955	Repair of maxillofacial soft and/ or hard tissue defect ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$200
D7961	Buccal/labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$120
D7963	Frenuloplasty ▪ Limited to 1 per arch per visit	$120
D7970	Excision of Hyperplastic Tissue - Per Arch ▪ Limited to 1 per arch per visit	$175
D7971	Excision of Pericoronal Gingival	$80
D7972	Surgical Reduction of Fibrous Tuberosity ▪ Limited to once per quadrant per date of service	$100
D7979	Non-surgical Sialolithotomy	$155
D7980	Sialolithotomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$155
D7981	Excision of salivary gland, by report ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$120

D7982	Sialodochoplasty ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$215
D7983	Closure of salivary fistula ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$140
D7990	Emergency tracheotomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
D7991	Coronoidectomy ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$345
D7995	Synthetic graft – mandible or facial bones, by report ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar ▪ Limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$350
ADJUNCTIVE GENERAL SERVICES ***(Not subject to payment of the Annual Deductible.)***		
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor ▪ Limited to once per date of service regardless of the number of teeth and/ or areas treated	$30
D9120	Fixed partial denture sectioning ▪ covered when at least one of the abutment teeth is to be retained	$95
D9210	Local Anesthesia not in conjunction with Operative or Surgical Procedures ▪ Limited to once per date of service	$10

D9211	Regional block anesthesia ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$20
D9212	Trigeminal division block anesthesia ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$15
D9222	Deep sedation/general anesthesia – first 15 minutes	$45
D9223	Deep Sedation/General Anesthesia - Each 15 Minute Increment	$45
D9230	Inhalation of Nitrous Oxide/Anxioloysis, Analgesia	$15
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	$60
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each 15 Minute Increment	$60
D9248	Non-Intravenous Conscious Sedation ▪ Limited to once per date of service	$65
D9310	Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$50
D9410	House/ Extended care facility call ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$50
D9420	Hospital or ambulatory surgical center call ▪ The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. ▪ Covered when medically necessary	$135
D9430	Office Visit – Observation (during regularly scheduled hours) – no other services performed ▪ Limited to once per date if service	$20

D9440	Office Visit – after regularly scheduled hours ▪ Limited to once per date of service	$45
D9610	Therapeutic parental drug, single administration ▪ Limited to a maximum of 4 injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications ▪ Covered when medically necessary	$40
D9910	Application of desensitizing medicament ▪ Limited to once in a 12-month period	$20
D9930	Treatment of Complications (post-surgical) - Unusual Circumstances, by report ▪ Limited to once per date of service	$35
D9950	Occlusion analysis – mounted case ▪ Limited to once in a 12-month period	$120
D9951	Procedure Occlusal Adjustment – Limited ▪ Limited to once in a 12-month period per quadrant	$45
D9952	Occlusal Adjustment – Complete ▪ Limited to once in a 12-month period following occlusion analysis	$210
D9997	Dental Case Management – patients with special health care needs	No charge
D9999	Unspecified adjunctive procedure, by report	No charge
MEDICALLY NECESSARY ORTHODONTICS (Not subject to payment of the Annual Deductible.)		
D8080	Comprehensive orthodontic treatment of the adolescent dentition ▪ Limited to once per patient per phase of treatment	$350
D8210	Removable appliance therapy ▪ Limited to once per patient	
D8220	Fixed appliance therapy ▪ Limited to once per patient	
D8660	Pre-orthodontic treatment visit ▪ Limited to once every 3 months	
D8670	Periodic orthodontic treatment visit (as part of contract) ▪ Limited to once per calendar quarter	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ▪ Limited to once per arch for each authorized phase of orthodontic treatment	
D8681	Removable orthodontic appliance ▪ Limited to once per appliance	

D8696	Repair of orthodontic appliance – maxillary ▪ Limited to once per appliance	
D8697	Repair of orthodontic appliance – mandibular ▪ Limited to once per appliance	
D8698	Re-cement or re-bond fixed retainer – maxillary ▪ Limited to once per appliance	
D8699	Re-cement or re-bond fixed retainer – mandibular ▪ Limited to once per appliance	
D8701	Repair of fixed retainer, includes reattachment – maxillary ▪ Limited to once per appliance	
D8702	Repair of fixed retainer, includes reattachment – mandibular ▪ Limited to once per appliance	
D8703	Replacement of lost or broken retainer – maxillary ▪ Limited to once per appliance	
D8704	Replacement of lost or broken retainer – mandibular ▪ Limited to once per appliance	
D8999	Unspecified orthodontic procedure, by report ▪ Limited to once per provider	

Please review the Evidence of Coverage for additional details, including exclusions relating to the benefits listed above.

Administration of these plan designs must comply with the requirements of the pediatric dental Essential Health Benefit (EHB) benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Section 8: General Exclusions and Limitations

Section 8.1 Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through an Addendum to the Group Agreement, the following are not Covered:

A. Dental Services that are not Necessary.

B. Costs for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Subscriber's home. When deemed Necessary by the Primary Care Dentist, the Subscriber's Physician and authorized by us, Covered Dental Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the Schedule of Covered Dental Services.

C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.

E. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

F. Any Dental Procedure not directly associated with dental disease.

G. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.

H. Procedures that are considered to be Experimental or Investigational. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational in the treatment of that particular condition.

I. Placement of dental implants, implant-supported abutments and prostheses.

J. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

K. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Member by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

L. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

M. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

N. Replacement of complete dentures, fixed and removable partial dentures or crowns and, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

O. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

P. Expenses for Dental Procedures begun prior to the Member becoming enrolled under the Group Agreement.

Q. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.

R. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

S. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

T. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

U. Services rendered by a provider who is a member of a Member's family, including spouse, brother, sister, parent or child.

V. Dental Services otherwise Covered under the Group Agreement, but rendered after the date individual Coverage under the Group Agreement terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Group Agreement terminates.

W. Orthodontic Services unless deemed medically necessary.

X. Foreign Services are not Covered unless required as an Emergency.

Y. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Z. Any Dental Services or Procedures not listed as a Covered Dental Service in this Certificate unless medically necessary.

AA. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.

BB. Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.

CC. Cephalometric x-rays

DD. Treatment which requires the services of a pediatric specialist, after the Member's 6th birthday.

EE. Consultations for non-Covered services.

FF. A service started but not completed prior to the Member's eligibility to receive benefits under the plan. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.

GG. A service started (as defined above) by a Non-Participating Dentist. This will not apply to Covered Emergency Dental Services.

HH. Procedures performed to facilitate non-Covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

II. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

Section 8.2 Limitations

DIAGNOSTIC AND PREVENTIVE SERVICES

A. Bitewing x-rays. Limited to 2 series of films per calendar year.

B. Intraoral - Complete Series (including bitewings). Limited to 1 time per consecutive 24months

C. Panoramic Film. Limited to 1time per consecutive 24months.

D. Prophylaxis – adult and child. Limited to 2 times per consecutive 12 months.

E. Sealant - Per Tooth. Once per first or second permanent molar.

PERIODONTICS

A. Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

B. Periodontal Scaling and Root Planing. Limited to 5 quadrant treatments per consecutive 12 months.

CROWNS, FIXED AND REMOVABLE PROSTHODONTICS

A. Replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1time per consecutive 36months.

B. Office or Laboratory Rebases and Relines. Limited to 1 time per consecutive 12months.

C. Tissue Conditioning. Limited to 2 times per denture.

ADJUNCTIVE SERVICES

A. Palliative (Emergency) Treatment of Dental Pain - Minor Procedure. Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.

B. Occlusal Guard, by report. Limited to 1 guard every consecutive 36months.

C. Occlusal Adjustment.

D. External Bleaching – Per Arch Limited to 1 per arch per consecutive 36 months.

PCA883245_000

NICE Plan Code:
1E0,1E1,10A,10B,10D,10E,10F,10G,10H,10I,10J,
10K,10L,10M,10N,10O,10P,10Q,10R,10S,10T,
10U,10V,10W,10X,10Y,11D,11E,11F,11G,11H,11I
,11J,11K,11L,11M,11N,11O,11P,11Q,11R,11S,
11T,11U,11V,11W,12O,13O,14O,15O,16O,17O,
18O,19O,1A0,1AK,1AM,1AN,1AO,1B0,1BN,1BO,
1BP,1BQ,1C0,1D0,1D1,1DM,1DP,1DQ,1DR,1F0,
1F1,1G0,1G1,1H0,1H1,1I0,1I1,1J0,1J1,1K0,1K1,
1L0,1L1,1M1,1N0,1N1,1O0,1O1,1O2,1O3,1O4,
1O5,1O6,1O7,1P0,1P1,1Q0,1Q1,1R0,1R1,1S0,
1T1,1U0,1U1,1UO,1V0,1V1,1VO,1W0,1W1,1WO,
1X1,1XO,1Y1,9VZ,9W0,9W8,9W9,9X0,9X7,9X8,
9X9

CAL CHOICE Plan Code:
1E8,1A9,1B8,1B9,1C8,1C9,1D8,1D9,1G8,1GB,
1GP,1HB,1I8,1K8,1L8,1M8,1N8,1Q8,1R8,1S8,1T8
,1U8,1W8,1X8,1Y8,1Z0,1Z1,1Z8

PRIME Plan Code:
CE-OK,CE-OL,CP-SG,CP-SM,CP-SU,CW-X2,
CW-X3,CW-X4,CW-X5,CW-X6,CW-X7,
CW-X8,CW-X9,CW-XX,CW-XY,CW-XZ,
CW-YA,CW-YB,CW-YC,CW-YD,CW-YE,
CW-YF,CW-YG,CW-YH,CW-YI,CW-YJ,
CW-YK,CW-YL,CW-YM,CW-YN,CW-YO

P.O. Box 25817
Santa Ana, CA 92799-5187

Customer Service:
800-228-3384
877-735-2929 (TTY)

Effective 1/1/2023

CALIFORNIA

UnitedHealthcare of California

Combined Evidence of Coverage and Disclosure Form (HMO)
Small Business Plans
Effective January 1, 2023

CALIFORNIA*CHOICE*

SUPPLEMENT TO

EVIDENCE OF COVERAGE

WELCOME TO CALIFORNIA*CHOICE*

Your Employer has chosen to offer your health coverage to you and your fellow Employees through the California*Choice* Program. This Supplement is to _____'s ("PLAN") Evidence of Coverage, into which this California*Choice* Supplement is inserted. All of the provisions of that Evidence of Coverage are applicable to your health coverage. This Supplement explains certain details specific to the California*Choice* Program and may duplicate what is already stated in that document. In the case of inconsistencies between the attached Evidence of Coverage and this document, the provisions of this document will control.

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

The California*Choice* Program is a program through which a number of California health care service plans and insurance carriers together offer various health benefits plans to employers for their employees' coverage. You as an Employee have the opportunity to select to receive your health benefits from one of these health plans or, in some circumstances, an insurance carrier. This gives you the sort of choice of health plans that typically has been enjoyed by only a few.

You have selected PLAN as the health care service plan from which you wish to receive your employer-sponsored medical benefits and you and your eligible Dependents have become members of PLAN.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an Enrollee in PLAN are listed below.

1. <u>Participation Requirements</u>

   At least seventy percent (70%) of your fellow Employees will receive their medical coverage from one of the health plans or the insurance carrier participating in the California*Choice* Program.

2. <u>Eligibility Requirements</u>

   a. Employee Eligibility

      An Eligible Employee is one who lives or works in PLAN's Service Area, who is permanently and actively employed for compensation an average of 30 hours per

week over the course of a month, at the small employer's regular place of business, and who has met any applicable waiting period requirements.

- Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary or substitute basis.

- Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:

  • They otherwise meet the definition of an Eligible Employee except for the number of hours worked

  • The employer offers the employees health coverage under a health benefit plan

  • All similarly situated employees are offered coverage under the health benefit plan

  • The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request). Individuals who work on a part-time, temporary or substitute basis are not eligible. If you are accepted for enrollment in PLAN, your coverage will become effective on the first day of the month following your Employer's designated waiting period of 30 days.

b. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee. A spouse may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below. A domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child of, a legal ward of, or adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled, disability diagnosed prior to age 26)
- This "child" profile describes herein an "eligible dependent child."

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until such disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit Administrators requests it.

California*Choice* Benefit Administrators will provide subscriber a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless subscriber provides written certification from a competent health care professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

California*Choice* Benefit Administrators or PLAN will determine if the child meets the conditions above prior to the child reaching the age limit. After two years following the child's reaching the limiting age, California*Choice* Benefit Administrators or PLAN may request proof of continuing incapacity and dependency, but not more often than yearly. If the Employee is enrolling a disabled child for new coverage, California*Choice* Benefit Administrators or PLAN may request initial proof of incapacity/dependency and then yearly, and the Employee must provide the requested information within 60 days of receipt of request.

If you are enrolling Dependents, they must also enroll in the same plan you have selected. Enrollees and their Dependents are, however, able to select different primary care physicians.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

New Dependents

(i) New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premium is charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee enrollee requesting coverage for such new Dependent must provide a stamped copy of the marriage certificate. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of marriage.

(ii) New Dependent - Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, adoption or placement for adoption or effective date of a guardianship order, or arrival at status of eligible dependent child, for coverage effective as of effective date of such event, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such birth, adoption or placement for adoption or legal guardianship or arrival at status of eligible dependent child, with coverage to be effective upon the date of the event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month, Premiums are charged for the full month. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation may be required).

(iii) New Dependent - Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to the

California*Choice* Program within 60 days following the date of the Enrollee's marriage to, or establishment of a registered domestic partnership with, the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the marriage certificate to, or a State-stamped copy of the Declaration of Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or establishment of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or establishment of the domestic partnership. If the marriage or establishment of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

(iv) New Dependent - Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- Have filed a Declaration of Domestic Partnership with the Secretary of State

- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request to the California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Declaration of Domestic Partnership within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request and Declaration to California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed established when both partners file the properly executed Declaration

of Domestic Partnership with the California Secretary of State. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

a. Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption or placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event;

- to add Employee and spouse or domestic partner after marriage or establishment of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/establishment of domestic partnership, coverage for Employee and spouse or domestic partner is effective on the date of marriage or establishment of domestic partnership; If all required documentation is received on or after the 16th day of the month of marriage/establishment of domestic partnership, coverage is effective on the 1st of the month following the date of receipt.

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;

- to add Employee and Employee's stepchild, if marriage or establishment of domestic partnership occurs before the 16th day of the month, coverage effective as of the date of marriage or establishment of domestic partnership; if marriage or establishment of domestic partnership occurs on or after the 16th day of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please see the "Late Enrollment" section below and the "Eligibility" section above for further information regarding rights to request enrollment at a later time.

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above

under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);
- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;
- is mandated to be covered as a dependent pursuant to a valid state or federal court order;
- has been released from incarceration;
- health coverage issuer substantially violated a material provision of the health coverage contract;
- gains access to new health benefit plans as a result of a permanent move;
- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;
- is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service; and
- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

then if such a triggering event occurs, the Employee may enroll in PLAN by submitting an enrollment application to California*Choice* Benefit Administrators within 60 days of loss of other coverage or within 60 days of another triggering event listed immediately above, pursuant to H&S section 1357.500(f) and as articulated further in PLAN's EOC. Coverage with PLAN through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

4. Waiting Period

The waiting period for coverage, which shall be applicable for all Employees, is 0, 30 or 60 days plus the days until the first of the following month, not to exceed 90 days.

5. Benefits

Under the federal "Patient Protection and Affordable Care Act," your Employer is required to select one of four (4) "metal tier" options of benefits offered by PLAN, keyed to their "actuarial value" ("Bronze," "Silver," "Gold," "Platinum"). However, by participating in the California*Choice* Program, your Employer is able and may decide to offer to you two (2) neighboring metal tiers of benefits (Bronze/Silver, Silver/Gold, or Gold/Platinum) for you to choose from or even to offer three (3) neighboring metal tiers of benefits (Silver/Gold/Platinum) from which you could choose. Employees will then have the option to choose from the health plans and benefit plans offered within such metal tier options. The benefits you will have chosen to receive from PLAN are described in the Evidence of Coverage to which this Supplement is attached. You may not change your benefit plan within PLAN other than during its open enrollment period unless you experience a "triggering event" (see Paragraph 3 above). PLAN will make all benefit and coverage dispute determinations, although these determinations are subject to PLAN's grievance procedures.

a. Cal-COBRA and COBRA

PLAN has agreed to provide coverage for you if you are Cal-COBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your employer. Please examine your options carefully before declining this coverage.

b. Co-payments

As noted in the attached Evidence of Coverage, certain covered services and benefits are subject to co-payments which you will be required to make.

c. Plan Materials

PLAN will provide you with an identification card and its Evidence of Coverage ("EOC") and this Supplement, and will distribute its federally-required "Summary of Benefits and Coverage" ("SBC"). California*Choice* Benefit Administrators will post on its website a copy of PLAN's current SBC. (In lieu of hard copies, PLAN may notify Enrollee of where to obtain electronic copies of the EOC and California*Choice* EOC Supplement.)

6. Termination for Nonpayment of Premiums

On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by California*Choice* Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states: "Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts

listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your Plan can cancel your coverage for not paying the amount due. You can file a complaint with your PLAN and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your Plan Evidence of Coverage." Premium payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums when due, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail your Employer a "Notice of Start of Grace Period" stating that the Employer has until the end of the Grace Period, which lasts at least 30 consecutive days, in which to pay the Premiums due before any cancellation of unpaid coverage contracts will take effect. This Notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, including your Employer's responsibility to promptly send you a copy of the Notice of Start of Grace Period, consequences for nonpayment of Premiums due within that timeframe, as well as the right of your Employer to submit a grievance to the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been or will be improperly cancelled.

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the Notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a "Second Notice of Grace Period" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the membership agreement and coverage for you and all your Dependents will end on such date as is contained in the "Notice of End of Coverage" sent to your Employer . It is your Employer's responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. If the affected premium(s) is(are) not paid by the last day of the Grace Period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contacts(s) terminated on the last day of March).

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended;

(3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the 30-day grace period provided; (5) the right of your Employer to submit a grievance to the PLAN and /or the California Department of Managed Health Care if your Employer believes coverage has been improperly cancelled and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Agreement; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that you would be sent a similar Notice of End of Coverage, which would include a State-approved notice regarding the possibility that you could secure coverage either through the "Covered California" State Exchange or in the State's Medi-Cal Program and also providing you toll-free contact telephone numbers and an Internet website where you could obtain additional information about these opportunities.

7. Partial Payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the California*Choice* Program and fails to make premium payments for every one of its coverage contracts, the application of such Partial Premium Payment as is submitted will be made to specific coverage contracts according to a priority articulated in the Group Service Agreement Supplement that is part of your Employer's contract with each Plan. If the Partial Payment is adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer's Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the

highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g*., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
1) All Medical contract(s) (all must be paid in full or all terminate)
2) Dental contract with highest membership count
3) Dental contract with next highest membership count (repeated through all dental contracts)
4) Vision contract with highest membership count
5) Vision contract with next highest membership count (repeated through all vision contracts)
6) Chiropractic/acupuncture contract with highest membership count
7) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8) Life contract with the highest membership count
9) Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800-558-8003.

RENEWAL

If your Employer wishes to renew in PLAN through the California*Choice* Program upon the anniversary date of its contract with PLAN, your Employer must have a minimum of at least two (2) Eligible Employees (or such number as may come to be used in the Small Group Act to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at such later date as it meets such renewal qualification requirements.

THE REST IS THE SAME!

This Supplement merely describes the particular features of your coverage from PLAN because of PLAN's participation in the California*Choice* Program. You should refer to the Evidence of Coverage to which this is merely a Supplement for all other details regarding your membership in and receipt of health care services from PLAN.

Welcome to UnitedHealthcare of California

UnitedHealthcare provides health care coverage to Members who have properly enrolled in our plan and meet our eligibility requirements. To learn more about these requirements, see **Section 7. Member Eligibility.**

What is This Document?

This document is called a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your Health Plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 10. Definitions**.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership. You will learn about important topics like how to choose a Primary Care Physician (PCP) and what to do if you need hospitalization.

This *Combined Evidence of Coverage and Disclosure Form* includes:

- The *Schedule of Benefits*, including the HMO *Schedule of Benefit*s, Pharmacy *Schedule of Benefits*, Acupuncture *Schedule of Benefits*, and, if purchased, Chiropractic *Schedule of Benefits*.
- The supplements to the Combined Evidence of Coverage and Disclosure Form including the Outpatient Prescription Drug Benefit, Mental and Substance-Related and Addictive Disorder Services, Pediatric Dental Coverage and Pediatric Vision Care Services.
- Language Assistance Disclosure Notice

What Else Should I Read to Understand My Benefits?

UnitedHealthcare HMO products may have a specifically defined Provider Network. You must receive all Covered Health Care Services through your Network Medical Group shown on your identification (ID) card, except for the following:

- Emergency Health Care Service provided by an Out-of-Network Provider.
- Urgently Needed Services provided by an Out-of-Network Provider
- Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician when not Emergency Health Care Services. For these Covered Health Care Services. "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.
- Air ambulance transport provided by an Out-of-Network Provider
- Authorized post-stabilization care, or

Other specific services authorized by your Network Medical Group or UnitedHealthcare, when you are away from the geographic area served by your Network Medical Group.

In addition to reading this document, be sure to review your *Schedule of Benefits, Provider Directory,* ID card, and any benefit materials. Your *Schedule of Benefits* provides the details of your particular Health Plan, including any Co-payments and Deductibles that you may have to pay when you receive Covered Health Care Services. The *Provider Directory* has detailed information about your specific Network's Network Medical Groups and other Providers, as well as the Service Area for this Network. Every Subscriber should receive a *Provider Directory*. If you need a copy or would like help picking your PCP, please call the telephone number on your ID card. You can also find an online version of the *The Provider Directory* at **www.myuhc.com**. These documents explain your coverage.

Not all UnitedHealthcare Network Providers may be part of the defined Network selected by your Employer Group and shown on your ID card. You must choose a PCP from the assigned Network to obtain the group benefits purchased by your employer. If you need a copy or would like help picking your PCP from the defined Network, please call UnitedHealthcare at the telephone number on your ID card.

For certain Covered Health Care Services, a limit is placed on the total amount you pay for Co-payments and Deductibles, if applicable, during a calendar or plan year. If you reach your Out-of-Pocket Limit, you may not be required to pay additional Co-payments or Deductibles for certain Covered Health Care Services.

You can find your Out-of-Pocket Limit in your *Schedule of Benefits*. If you believe you have met your Deductible or Out-of-Pocket Limit, submit all your health care receipts and a letter of explanation to UnitedHealthcare of California, to the address shown below. It is important to send us all health care receipts along with your letter since they confirm that you have reached your annual out-of-pocket limit.

What if I need information about the Plan in my language?

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may be available in some languages at no charge. To get help in your language, please call your Health Plan UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call **DMHC Help Line at 1-888-466-2219**.

California Law requires UnitedHealthcare to notify you every year that we will provide your information to Covered California if you end your health care coverage with us. Covered California will use this information to help you obtain other health coverage. If you do not want to allow UnitedHealthcare to share your information with Covered California, you may opt out of this information sharing. If you do not want us to share your information with Covered California, contact UnitedHealthcare using the phone number on the back of your ID card to opt out of this information sharing.

What if I Still Need Help?

After you become familiar with your benefits, you may still need help. Please do not hesitate to call UnitedHealthcare at 1-800-624-8822 or 711 (TTY).

Note: Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provide the terms and conditions of your coverage with UnitedHealthcare and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with UnitedHealthcare at the following address:

UnitedHealthcare of California
P.O. Box 30968
Salt Lake City, UT 84130-0968

1-800-624-8822

UnitedHealthcare's website is:

www.myuhc.com

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SECTION 1. GETTING STARTED: YOUR PRIMARY CARE PHYSICIAN

- **What is a PCP?**
- **What is a Subscriber?**
- **What is a Network Medical Group?**
- **Your *Provider Directory***
- **Choosing Your PCP**
- **Continuity of Care**

One of the first things you do when joining UnitedHealthcare is to choose a PCP. This is the doctor in charge of overseeing your care through UnitedHealthcare. This section explains the role of the PCP, as well as how to make your choice. You will also learn about your Network Medical Group and how to use your *Provider Directory.*

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Introduction

Now that you are a UnitedHealthcare Member, it is important to become familiar with the details of your coverage. Reading this document will help you understand your coverage and health care benefits. It is written for **all** our Members receiving this plan, whether you are the Subscriber or an enrolled Family Member.

Please read this *Combined Evidence of Coverage and Disclosure Form* along with any supplements you may have with this coverage. You should also read and become familiar with your *Schedule of Benefits*, which lists the benefits and costs specific to your plan.

What is a PCP?

When you become a Member of UnitedHealthcare, one of the first things you do is choose a doctor to be your PCP. This is a doctor who is contracted with UnitedHealthcare and who is mainly responsible for the coordination of your health care services. A PCP is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology. Others may take part in the coordination of your health care services, such as a Hospitalist. (Please refer to **Section 2. Seeing Your Doctor or Other Providers and Timely Access To Care** for information on Hospitalist programs.)

Unless you need Emergency Health Care Services or Urgently Needed Services, your PCP is your first stop for using these medical benefits. Your PCP will also seek authorization for any referrals, as well as begin any necessary Hospital Services. Either your PCP or a Hospitalist may provide the coordination of any needed Hospital Services.

All Members of UnitedHealthcare are required to have a PCP. If you do not choose one when you enroll, UnitedHealthcare will choose one for you. Except in an urgent or emergency situation or as described under Out-of-Area Services below, if you see another health care Provider without the approval of either your PCP, Network Medical Group or UnitedHealthcare, the costs for these services will not be covered.

What is the Difference Between a Subscriber and an Enrolled Family Member?

While both are Members of UnitedHealthcare, there is a difference between a Subscriber and an enrolled Family Member. A Subscriber is the Member who enrolls through his or her employment after meeting the eligibility requirements of the Employer Group and UnitedHealthcare. A Subscriber may also contribute toward a portion of the premiums paid to UnitedHealthcare for his or her health care coverage for him or herself and any enrolled Family Members. An enrolled Family Member is someone such as legal spouse, Domestic Partner, or child whose Dependent status with the Subscriber allows him or her to be a Member of UnitedHealthcare. Why point out the difference? Because Subscribers often have special responsibilities, including sharing benefit updates with any enrolled Family Members. Subscribers also have special responsibilities that are noted throughout this document. If you are a Subscriber, please pay attention to any

instructions given specifically for you. For a more detailed explanation of any terms, see **Section 10: Definitions** section of this document.

A STATEMENT DESCRIBING UNITEDHEALTHCARE'S POLICIES AND PROCEDURES FOR MAINTAINING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE PROVIDED TO YOU UPON REQUEST.

Choosing a PCP

When choosing a PCP, you should always make certain your doctor meets the following criteria:

- Your doctor is chosen from the list of PCPs in UnitedHealthcare's *Provider Directory*.
- Your doctor is located within 30 miles of either your Primary Residence or Primary Workplace.

You'll find a list of our Network PCPs in the *Provider Directory*. It is also a source for other valuable information. (**Note:** If you are pregnant, please read the section below, "What to do If You Are Pregnant," to learn how to choose a PCP for your newborn.)

What is a Network Medical Group?

When you choose a PCP, you are also choosing a Network Medical Group. This is the group that is affiliated with both your doctor and UnitedHealthcare. If you need a referral to a Specialist or Non-Physician Health Care Practitioner, you will generally be referred to a doctor, Non-Physician Health Care Practitioner or service within this Network Medical Group. Since Network Medical Groups are independent contractors not employed by UnitedHealthcare, each has its own specific Network of affiliated Specialists and Providers. Only if a Specialist, Non-Physician Health Care Practitioner or service is unavailable will you be referred to a health care Provider outside your Network Medical Group.

To learn more about a particular Network Medical Group, look in your *Provider Directory* where you will find addresses and phone numbers, and other important information about hospital affiliations or any restrictions on the availability of certain Providers.

Your *Provider Directory* – Choice of Physicians and Hospitals (Facilities)

Along with listing our Network Physicians, your *Provider Directory* has detailed information about our Network Medical Groups and other Providers. Every Subscriber should receive a *Provider Directory*. If you need a copy or would like help choosing your PCP, please call UnitedHealthcare at the telephone number on your ID card. You can also find an online version of the Directory at **www.myuhc.com**.

If you receive a Covered Health Care Service from an Out-of-Network Provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network Provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment and applicable Deductible) that would be no greater than if the service had been provided from a Network Provider.

Note: If you are seeing a Network Provider who is not a part of a Network Medical Group, your doctor will coordinate services directly with UnitedHealthcare.

Choosing a PCP for Each Enrolled Family Member

Every UnitedHealthcare Member must have a PCP; however, the Subscriber and any enrolled Family Members do not need to choose the same doctor. Each UnitedHealthcare Member can choose his or her own PCP, so long as the doctor is chosen from UnitedHealthcare's list of PCPs and the doctor is located within 30 miles of either the Member's Primary Residence or Primary Workplace.

If a Family Member does not make a selection during enrollment, UnitedHealthcare will choose the Member's PCP. (**Note:** If an enrolled Family Member is pregnant, please read below to learn how to choose a PCP for the newborn.)

Continuity of Care for New Members at the Time of Enrollment

Under certain circumstances, as a new Member of UnitedHealthcare, you may be able to continue receiving services from an Out-of-Network Provider to allow for the completion of Covered Health Care Services provided by an Out-of-Network Provider, if you were receiving services from that Provider at the time your coverage became effective, for one of the Continuity of Care Conditions as limited and described in **Section 10. Definitions**.

This Continuity of Care help is intended to facilitate the smooth transition in medical care across health care delivery systems for new Members who are undergoing a course of treatment when the Member or the Member's employer changes Health Plans during the Open Enrollment Period.

For a newly enrolled Member to continue receiving care from an Out-of-Network Provider, the following conditions must be met:

1. Your Employer Group did not offer you a PPO plan or other plan that would provide you with an out-of-Network benefit or would allow you to continue to obtain services from your Out-of-Network Provider;
2. A request for Continuity of Care services from an Out-of-Network Provider must be submitted to UnitedHealthcare within 30 calendar days from your effective date on the Health Plan for review and approval.
3. The requested treatment must be a Covered Health Care Service under this Health Plan;
4. The Out-of-Network Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon UnitedHealthcare's Network Providers, including location within UnitedHealthcare's Service Area, payment methodologies and rates of payment.

Covered Health Care Services for the Continuity of Care Condition under treatment by the Out-of-Network Provider will be considered complete when:

1. The Member's Continuity of Care Condition under treatment is medically stable; and
2. There are no clinical contraindications that would prevent a medically safe transfer to a Network Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the Out-of-Network Provider and, as applicable, the newly enrolled Member's assigned Network Provider.

Continuity of Care also applies to those new UnitedHealthcare Members who are receiving Mental Health Care Services from an Out-of-Network Mental Health Provider at the time their coverage becomes effective. Members eligible for continuity of Mental Health Care Services may continue to receive Mental Health Care services from an Out-of-Network Provider for a reasonable period of time to safely transition care to a Mental Health Network Provider. Please refer to Medical Benefits and Exclusions and Limitations in **Section 5. Your Medical Benefits** of the UnitedHealthcare *Combined Evidence of Coverage and Disclosure Form*, and additional Mental Health Care Services coverage information. For a description of coverage of Mental Health Care Services and Substance-Related and Addictive Disorder Services, please refer to **Section 5. Your Medical Benefits** and to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for U.S. Behavioral Health Plan, California (USBHPC). An Out-of-Network Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the Network of Providers from whom the Member is entitled to receive Covered Health Care Services.

Complete and return the form to UnitedHealthcare as soon as possible, but no later than 30 calendar days of the Member's effective date of enrollment. Exceptions to the 30-calendar-day time frame will be considered for good cause.

The address is:

UnitedHealthcare
Attention: Continuity of Care Department
Mail Stop: CA124-0181
P.O. Box 30968
Salt Lake City, UT 84130-0968
Fax: 1-888-361-0514

All Continuity of Care requests will be reviewed on a case-by-case basis. We will consider the severity of the newly enrolled Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

UnitedHealthcare's Health Care Services department will complete a clinical review of your Continuity of Care request for the completion of Covered Health Care Services with an Out-of-Network Provider and the decision will be made and communicated in a timely manner appropriate to the nature of your medical condition. In most instances, decisions for non-urgent requests will be made within five(business days of UnitedHealthcare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States' mail, within two business days of making the decision. If your request for continued care with an Out-of-Network Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

If you have any questions, would like a description of UnitedHealthcare's Continuity of Care process, or want to appeal a denial, please call the telephone number listed on your ID card.

Please Note: It is not enough to simply prefer receiving treatment from a former Physician or other Out-of-Network Provider. You should not continue care with an Out-of-Network Provider without our formal approval. If you do not receive Prior Authorization from UnitedHealthcare or your Network Medical Group, payment for routine services performed by an Out-of-Network Provider will be your responsibility.

What to do If you are Pregnant?

Every Member of UnitedHealthcare needs a PCP, including your newborn. Newborns are assigned to the mother's Network Medical Group from birth until discharge from the Hospital. You may request to reassign your newborn to a different PCP or Network Medical Group following the newborn's discharge by calling UnitedHealthcare. If a PCP is not chosen for your child, the newborn will remain with the mother's PCP or Network Medical Group. If you call UnitedHealthcare by the 15th of the current month, your newborn's transfer will be effective on the first day of the following month. If the request for transfer is received after the 15th of the current month, your newborn's transfer will be effective the first day of the second succeeding month. For example, if you call UnitedHealthcare on June 12th to request a new doctor for your newborn, the transfer will be effective on July 1st. If you call UnitedHealthcare on June 16th, the transfer will be effective August 1st. In order for coverage to continue beyond the first 60 days of life, the Subscriber must submit a request to add the baby to his or her Employer Group prior to the expiration of the 60-day period to continue coverage beyond the first 60 days of life. If you do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth).

If your newborn has not been discharged from the hospital, is being followed by the Case Management or is receiving acute institutional or non-institutional care at the time of your request, a change in your newborn's PCP or Network Medical Group will not be effective until the first day of the second month following the newborn's discharge from the institution or termination of treatment. When UnitedHealthcare's Case Management is involved, the Case Manager is also consulted about the effective date of your requested Physician change for your newborn.

You can learn more about changing PCPs in **Section 4. Changing Your Doctor or Medical Group**. For more information on how we may coordinate your newborn's benefits, please see Section 6. Coordination of Benefits and for more information about adding a newborn to your coverage, see **Section 7. Member Eligibility.**

Does your Group or Hospital Restrict any Reproductive Services?

Some hospitals and other Providers do not provide one or more of the following services that may be covered under your Health Plan contract and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call UniteHealthcare at 1-800-624-8822 or 711 (TTY) to ensure that you can get the health care services that you need.

If you have chosen a Network Medical Group that does not provide the family planning benefits you need, and these benefits have been purchased by your Employer Group, please call UnitedHealthcare.

SECTION 2. SEEING THE DOCTOR OR OTHER PROVIDERS AND TIMELY ACCESS TO CARE

- **Scheduling Appointments**
- **Referrals to Specialists**
- **OB/GYN and Other Services/ Getting Care Without a Referral**
- **Second Medical Opinions**
- **Prearranging Hospital Stays**
- **24-Hour Support and Information**
- **Timely Access To Care**

Now that you have chosen a PCP, you have a doctor for your routine health care.

This section will help you begin taking advantage of your health care coverage. It will also answer common questions about seeing a Specialist and receiving medical services that are not Emergency Health Care Services or Urgently Needed Services. (For information on Emergency Health Care Services or Urgently Needed Services, please turn to **Section 3**.)

Seeing the Doctor: Scheduling Appointments

To visit your PCP, simply make an appointment by calling your doctor's office.

Your PCP is your first stop for accessing routine, non-emergent care. No Physician or other health care services will be covered without an authorized referral from your PCP or UnitedHealthcare except for Emergency Health Care Services, Urgently Needed Services, services described under *Out-of-Area Services,* and exceptions found below under "OB/GYN and Other Services/ Getting Care Without a Referral".

When you see your PCP or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Co-payment and Deductible, if applicable. The amount of a Co-payment depends upon the Covered Health Care Service. Your Co-payments and Deductibles are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section 6. Payment Responsibility**.

Referrals to Specialists and Non-Physician Health Care Practitioners

The PCP you have chosen will coordinate your health care needs. If your PCP determines you need to see a Specialist or Non-Physician Health Care Practitioner, he or she will make an appropriate referral. (There is an exception for visits to obstetrical and gynecological (OB/GYN) Physicians. This is explained below in "Direct Access to OB/GYN Services.")

Your plan may not cover services provided by all Non-Physician Health Care Practitioners. Please refer to the Medical Benefits and Exclusions and Limitations section in this *Agreement and Evidence of Coverage and Disclosure Form* for further information regarding Non-Physician Health Care Practitioner services excluded from coverage or limited under this Health Plan.

Your PCP will determine the number of Specialist or Non-Physician Health Care Practitioner visits that you require and will provide you with any other special instructions. This referral may also be reviewed by, and may be subject to the approval of, the PCP's Utilization Review Committee. For more information regarding the role of the Utilization Review Committee, please see **Section 10: Definitions** for definition of "Utilization Review Committee." A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

Standing Referrals to Specialists

A standing referral is a referral by your PCP that authorizes more than one visit to a Network Specialist. A standing referral may be provided if your PCP, in consultation with you, the Specialist and your Network

Medical Group's Medical Director (or a UnitedHealthcare Medical Director), determines that as part of a treatment plan you need continuing care from a Specialist. You may request a standing referral from your PCP or UnitedHealthcare. **Please Note:** A standing referral and treatment plan is only allowed if approved by your Network Medical Group or UnitedHealthcare.

Your PCP will specify how many Specialist visits are authorized. The treatment plan may limit your number of visits to the Specialist and the period for which visits are authorized. It may also require the Specialist to provide your PCP with regular reports on your treatment and condition.

Extended Referral for Care by a Specialist

If you have a life-threatening, degenerative or disabling condition or disease that requires specialized medical care over a prolonged period, you may receive an extended specialty referral. This is a referral to a Specialist or specialty care center so the Specialist can oversee your health care. The Physician or center will have the needed experience and skills for treating the condition or disease.

You may request an extended specialty referral by asking your PCP or UnitedHealthcare. Your PCP must then determine if it is Medically Necessary. Your PCP will consult with the Specialist or specialty care center, as well as your Network Medical Group's Medical Director or a UnitedHealthcare Medical Director.

If you require an extended specialty referral, the referral will be made according to a treatment plan approved by your Network Medical Group's Medical Director or a UnitedHealthcare Medical Director. This is done by consulting with your PCP, the Specialist and you.

Once the extended specialty referral begins, the Specialist begins serving as the main coordinator of your care. The Specialist does this in agreement with your treatment plan.

OB/GYN and Other Services/ Getting Care Without a Referral

Women may receive obstetrical and gynecological (OB/GYN) Physician services directly from a Network OB/GYN, family practice Physician, or surgeon shown by your Network Medical Group as providing OB/GYN Physician services. This means you may receive these services without Prior Authorization or a referral from your PCP. In all cases, however, the doctor must be affiliated with your Network Medical Group.

Please Remember: if you visit an OB/GYN or family practice Physician not affiliated with your Network Medical Group without Prior Authorization or a referral, you will be financially responsible for these services. All OB/GYN inpatient or Hospital Services, except Emergency Health Care Services or Urgently Needed Services, need to be authorized in advance by your Network Medical Group or UnitedHealthcare.

If you would like to receive OB/GYN Physician services, simply do the following:

- Call the telephone number on the front of your Health Plan ID card and request the names and telephone numbers of the OB/GYNs affiliated with your Network Medical Group;
- Contact your Network OB/GYN to schedule an appointment.

After your appointment, your OB/GYN will contact your PCP about your condition, treatment and any needed follow-up care.

UnitedHealthcare also covers important wellness services for our Members. For more information, see Health Education Services in **Section 5. Your Medical Benefits**.

Additionally, for reproductive and sexual health care services, prior approval from your PCP or Network Medical Group or the Health Plan is not necessary. Such services include:

- Prevention or treatment of pregnancy.
- Screening, prevention, , including HIV and HIV testing.
- Abortion
- diagnosis and treatment of an infectious, communicable or sexually transmitted disease

- Rape including the medical care related to the diagnosis or treatment of the condition and the collection of medical evidence and may be provided under Section 3. Emergency Health Care Services.
- Sexual assault including the medical care related to the diagnosis or treatment of the condition and the collection of medical evidence.

UnitedHealthcare may establish reasonable provisions governing utilization procedures for obtaining services. Although prior authorization is not needed, you may be able to receive these services from your Network Medical Group.

Second Medical Opinions

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Provider. This Provider must be either a PCP or a Specialist acting within his or her scope of practice, and must possess the clinical background needed for examining the illness or condition related to the request for a second medical opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Either you or your treating Network Provider may submit a request for a second medical opinion. Requests should be submitted to your Network Medical Group; however, in some cases, the request is submitted to UnitedHealthcare. To find out how you should submit your request, talk to your PCP.

Second medical opinions will be provided or authorized in the following circumstances:

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment (including, but not limited to, a serious chronic condition);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating Provider is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;
- When you have attempted to follow the treatment plan or consulted with the first Provider and still have serious concerns about the diagnosis or treatment.

Either the Network Medical Group or, if applicable, a UnitedHealthcare Medical Director will approve or deny a request for a second medical opinion. The request will be approved or denied in a timely fashion appropriate to the nature of your condition. For circumstances other than an imminent or serious threat to your health, a second medical opinion request will be approved or denied within five business days after the request is received by the Network Medical Group or UnitedHealthcare.

When there is an imminent and serious threat to your health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Network Medical Group or UnitedHealthcare. An imminent and serious threat includes the potential loss of life, limb or other major bodily function, or where a lack of timeliness would be harmful to your ability to regain maximum function.

If you are requesting a second medical opinion about care given by your PCP, the second medical opinion will be provided by an appropriately qualified health care professional of your choice within the same Network Medical Group. (If your PCP is independently contracted with UnitedHealthcare and not affiliated with any Network Medical Group, you may request a second opinion from a PCP listed in our *Provider Directory*.) If you request a second medical opinion about care received from a Specialist, the second medical opinion will be provided by any Specialist within of your choice from within your Network Medical Group or any medical group within the UnitedHealthcare Provider Network of the same or equivalent specialty.

The second medical opinion will be documented in a consultation report, which will be made available to you and your treating Network Provider. It will include any recommended procedures or tests that the Provider giving the second opinion believes are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by UnitedHealthcare – and the recommendation is determined to be Medically Necessary by your Network Medical Group or UnitedHealthcare – the treatment, diagnostic test or service will be provided or arranged by your Network Medical Group or UnitedHealthcare.

For Second opinions on Mental Health and Substance-Related and Addictive Disorder issues, please refer to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for USBHPC.

Please Note: The fact that an appropriately qualified Provider gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is Medically Necessary or a Covered Health Care Service. You will also remain responsible for paying any outpatient office Co-payments or Deductibles to the Provider who gives your second medical opinion.

If your request for a second medical opinion is denied, UnitedHealthcare will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section 8. Overseeing Your Health Care**. If you get a second medical opinion without Prior Authorization from your Network Medical Group or UnitedHealthcare, you will be financially responsible for the cost of the opinion.

To receive a copy of the Second Medical Opinion timeline, you may call or write to:

UnitedHealthcare
P.O. Box 30968
Salt Lake City, UT 84130-0968

1-800-624-8822

What is UnitedHealthcare's Case Management Program?

UnitedHealthcare has licensed registered nurses who, in collaboration with the Member, Member's designated family and the Member's Network Medical Group, may help arrange care for UnitedHealthcare Members experiencing a major illness or recurring hospitalizations. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources. Not every Member will be assigned a case manager.

Prearranging Hospital Stays

Your PCP or Hospitalist will prearrange any Medically Necessary hospital or Facility care, inpatient care provided in a Subacute/Skilled Nursing Facility. If you have been referred to a Specialist and the Specialist determines you need hospitalization, your PCP or Hospitalist will work with the Specialist to prearrange your hospital stay.

Your hospital costs, including semi-private room, tests and office visits, will be covered, minus any required Co-payments, as well as any Deductibles. Under normal circumstances, your PCP or Hospitalist will coordinate your admission to a local UnitedHealthcare Network Hospital or Facility; however, if your situation requires it, you could be transported to a regional medical center.

If Medically Necessary, your PCP or Hospitalist may discharge you from the hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for Home Health Care Visits.

Please Note: If a Hospitalist program applies, a Hospitalist may direct your inpatient hospital or facility care in consultation with of your PCP.

Hospitalist Program

If you are admitted to a Network Hospital for a Medically Necessary procedure or treatment, a Hospitalist may coordinate your Health Care Services in consultation with your PCP. A Hospitalist is a dedicated hospital-based Physician who assumes the primary responsibility for managing the process of inpatient care for Members who are admitted to a hospital. The Hospitalist will manage your hospital stay, monitor your progress, coordinate and consult with Specialists, and communicate with you, your family and your PCP. Hospitalists will work together with your PCP during the course of your hospital stay to ensure coordination and Continuity of Care and to transition your care upon discharge. Upon discharge from the hospital, your PCP will again take over the primary coordination of your health care services.

24-Hour Support and Information

Call the number on the back of your ID card or log into myuhc.com to get connected with a health professional at any time. Here are some of the ways they can help you:

- Choose appropriate medical care.
- Provide guidance for current symptoms 24/7 (via a clinician).
- Find doctors or hospitals that meet your needs and preferences.
- Locate an urgent care center and other health resources in your area.

To use this convenient service, simply call the telephone number on your ID card or log into myuhc.com.

Note: If you have a medical emergency, call 911 or go to the nearest emergency room.

Timely Access To Care

The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointments even sooner than the law requires. In this case, your doctor can request that the appointment be sooner.

Sometimes waiting longer for care is not a problem. Your Provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health.

If Medically Necessary care from a provider within the Medical Group cannot be arranged timely, your Medical Group will make alternate arrangements for the required care with an available and accessible out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

In-person appointment wait times:

Urgent Appointments	**Wait time**
For services that do not need prior authorization	48 hours
For services that do need prior authorization	96 hours
Non-Urgent Appointments	**Wait time**
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care Provider (who is not a Physician)	10 business days

Follow-up appointments with a mental health care or substance use Provider (who is not a Physician). This does not limit coverage to once every 10 business days.	10 business days
Appointment for other services to diagnose or treat an injury, illness or other health condition	15 business days

Type of Network Provider	**Maximum Travel Distance or Travel Time**
Hospital	15 miles or 30 minutes
Primary Care Physician	15 miles or 30 minutes
Specialist	30 miles or 60 minutes
Mental Health Care Services and Substance-Related and Addictive Disorders professionals	15 miles or 30 minutes

Please refer to the "Timely Access to Care" standards above for additional information on access to care.

Telephone wait times:
You can call 24-hours-a-day, 7 days a week to talk to a qualified health professional to decide if your health problem is urgent. If someone needs to call you back, they must call you within 30 minutes. Look for the phone number on your Health Plan membership card.

If you call your Health Plan's telephone phone number, someone should answer the phone within 10 minutes during normal business hours.

Important Language Information:
You may be entitled to the right and services below. These rights apply only under California law. These rights shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services.

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your doctor or Health Plan. To get help in your language, please call your Health Plan at:

UnitedHealthcare of California 1-800-624-8822 / TTY: 711

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact your Health Plan at 1-800-624-8822 / TTY: 711.

If you need more help, call **DMHC Help Line at 1-888-466-2219.**

SECTION 3. EMERGENCY HEALTH CARE SERVICES AND URGENTLY NEEDED SERVICES

UnitedHealthcare provides coverage for Emergency Health Care Services and Urgently Needed Services wherever you are. This section will explain how to get Emergency Health Care Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

IF YOU BELIEVE YOU ARE EXPERIENCING AN EMERGENCY MEDICAL CONDITION, CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM FOR TREATMENT.

What are Emergency Health Care Services?

Emergency Health Care Services are Medically Necessary ambulance or ambulance transport services provided through the 911 emergency response system. It is also the medical screening, exam and evaluation by a Physician, or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition or Psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Health Care Services include the care, treatment and/or surgery by a Physician needed to stabilize or eliminate the Emergency Medical Condition or Psychiatric Emergency Medical Condition within the capabilities of the Facility which includes admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital for the purpose of providing care and treatment needed to relieve or eliminate a Psychiatric Emergency Medical Condition, if in the opinion of the treating Provider, it would not result in material deterioration of the Member's condition.

What is an Emergency Medical Condition or a Psychiatric Emergency Medical Condition?

The State of California defines an Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:

- Placing the Member's health in serious jeopardy;
- Serious impairment to his or her bodily functions;
- A serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would happen:
  - There is not enough time to effect a safe transfer to another hospital prior to delivery; or
  - A transfer poses a threat to the health and safety of the Member or unborn child.

An Emergency Medical Condition also includes a Psychiatric Emergency Medical Condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or others; or
- Unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

What to Do When You Require Emergency Health Care Services

If you believe you are experiencing an Emergency Medical Condition, call 911 or go directly to the nearest hospital emergency room for treatment. You do not need to get Prior Authorization if you reasonably believe Emergency Health Care Services are needed to seek treatment for an Emergency Medical Condition that could cause you harm. Ambulance transport services provided through the 911 emergency response system are covered if you reasonably believe that your medical condition requires emergency ambulance transport services. UnitedHealthcare covers all Medically Necessary Emergency Health Care Services provided to Members in order to stabilize an Emergency Medical Condition.

You, or someone else on your behalf, must notify UnitedHealthcare or your PCP within 24 hours, or as soon as reasonably possible, following your receipt of Emergency Health Care Services so that your PCP can coordinate your care and schedule any necessary follow-up treatment. When you call, please be prepared to give the name and location of the Facility and a description of the Emergency Health Care Services that you received.

Post-stabilization and Follow-up Care

Following the stabilization of an Emergency Medical Condition, the treating health care Provider may believe that you require additional Medically Necessary Hospital (health care) Services prior to your being safely discharged. If the hospital is not part of the contracted Network, the Hospital will contact your Network Medical Group, or UnitedHealthcare, in order to get the timely authorization for these post-stabilization services. If UnitedHealthcare determines that you may be safely transferred, and you refuse to consent to the transfer, the Hospital must provide you written notice that you will be financially responsible for 100 percent of the cost of services provided to you once your emergency condition is stable. Also, if the Hospital is unable to determine your name and contact information at UnitedHealthcare in order to request prior authorization for services once you are stable, it may bill you for such services.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, PLEASE CALL UNITEDHEALTHCARE AT 1-800-624-8822.

Following the stabilization of your Emergency Medical Condition, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your PCP in order to be covered by UnitedHealthcare. Regardless of where you are in the world, if you require additional follow-up medical or Hospital Services, please call your PCP or UnitedHealthcare's Out-of-Area unit to request authorization. *UnitedHealthcare's Out-of-Area unit can be reached during regular business hours (8 a.m. – 5 p.m., Pacific Time) at 1-800-542-8789.*

Out-of-Area Services

UnitedHealthcare arranges for the provision of Covered Health Care Services through its Network Medical Groups and other Network Providers. With the exception of the following, you are not covered for any other medical or Hospital Services out-of-area:

- Emergency Health Care Service provided by an Out-of-Network Provider.
- Urgently Needed Services provided by an Out-of-Network Provider
- Covered Health Care Services provided at certain Network faclities by an out-of-Network Physician when not Emergency Health Care Services. For these Covered Health Care Services. "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.
- Air ambulance transport provided by an Out-of-Network Provider
- Authorized post-stabilization care, or

- Other specific services authorized by your Network Medical Group or UnitedHealthcare, when you are away from the geographic area served by your Network Medical Group.

If you do not know the area served by your Network Medical Group, please call your PCP or the Network Medical Group's administrative office to inquire.

The out-of-area services that are not covered include, but are not limited to:

- Routine follow-up care to Emergency Health Care Services or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Care or home health care.
- Maintenance therapy and DME, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to help you while traveling outside the geographic area served by your Network Medical Group.
- Medical care for a known or Long Term Condition without acute symptoms as defined under Emergency Health Care Services or Urgently Needed Services.
- Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition in or out of the area.

Your Network Medical Group provides 24-hour access to request authorization for out-of-area care. You can also request authorization by calling the UnitedHealthcare Out-of-Area unit during regular business hours (8 a.m. – 5 p.m., Pacific Time) at 1-800-542-8789.

What to Do When You Require Urgently Needed Services

When you are in the geographic area served by your Network Medical Group, you should call your PCP or Network Medical Group. The telephone numbers for your PCP and/or Network Medical Group are on the front of your UnitedHealthcare Health Plan ID card. Help is available 24 hours a day, seven days a week. Identify yourself as a UnitedHealthcare Member and ask to speak to a Physician. If you are calling during non-business hours, and a Physician is not available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions. If your PCP or Network Medical Group is temporarily unavailable, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, must notify UnitedHealthcare or your Network Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

Out-of-Area Urgently Needed Services

Urgently Needed Services are Medically Necessary health care services required to prevent the serious deterioration of a Member's health, resulting from an unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the geographic area served by the Member's Network Medical Group.

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member's Network Medical Group and the Member experiences a medical condition that, while less serious than an Emergency Medical Condition, could result in the serious deterioration of the Member's health if not treated before the Member returns to the geographic area served by his or her Network Medical Group or contacts his or her Network Medical Group.

When you are temporarily outside the geographic area served by your Network Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your PCP or Network Medical Group as described above in "What to Do When You Require Urgently Needed Services." The telephone numbers for your PCP and/or Network Medical Group are on the front of your UnitedHealthcare Health Plan ID card. Help is available 24 hours a day, seven days a week. Identify

yourself as a UnitedHealthcare Member and ask to speak to a Physician. If you are calling during non-business hours, and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions.

If you are unable to contact your PCP or Network Medical Group, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, must notify UnitedHealthcare or your Network Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

International Emergency Health Care Services and Urgently Needed Services

If you are out of the country and require Urgently Needed Services, you should still, if possible, call your PCP or Network Medical Group. Follow the same instructions outlined above. If you are out of the country and experience an Emergency Medical Condition, either use the available emergency response system or go directly to the nearest hospital emergency room. Following receipt of Emergency Health Care Services, please notify your PCP or Network Medical Group within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Note: Under certain circumstances, you may need to initially pay for your Emergency Health Care Services or Urgently Needed Services. Please pay for such services and then contact UnitedHealthcare at the earliest opportunity. Be sure to keep all credit card statements, bank statements with copies of checks and receipts from Providers and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to UnitedHealthcare, please refer to **Section 6: Paymemt Responsability** in this *Combined Evidence of Coverage and Disclosure Form*.

ALWAYS REMEMBER

Emergency Health Care Services: Following receipt of Emergency Health Care Services, you, or someone else on your behalf, must notify UnitedHealthcare or your PCP within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Urgently Needed Services: When you require Urgently Needed Services inside of the geographic area served by your medical group, you should, if possible, call (or have someone else call on your behalf) your PCP or Network Medical Group. If you are **outside** of the geographic area served by your medical group you should call or have someone on your behalf call your PCP or Network Medical Group, and if you receive medical or Hospital Services, you must notify UnitedHealthcare or your PCP within 24 hours, or as soon as reasonably possible of initially receiving these services.

MEMBERS ARE NOT FINANCIALLY RESPONSIBLE FOR PAYMENT OF EMERGENCY HEALTH CARE SERVICES BEYOND THE CO-PAYMENTS AND DEDUCTIBLES.

SECTION 4. CHANGING YOUR DOCTOR OR MEDICAL GROUP

- **How to Change Your Primary Care Physician or Network Medical Group**
- **When We Change Your Network Medical Group**
- **Continuing Care With a Terminated Provider for Members**

This section explains how to change your PCP or Network Medical Group, as well as how we continue your care.

How to Change Your Primary Care Physician or Network Medical Group

Whether you want to change doctors within your Network Medical Group or transfer out of your Network Medical Group entirely, you should call UnitedHealthcare.

UnitedHealthcare will approve your request to change doctors within your Network Medical Group if the PCP you have chosen is accepting new patients and meets the other criteria in **Section 1. Getting Started**.

If you call us by the 15th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 15th of the current month, your transfer will be effective the first day of the following month. For example, if you meet the above requirements and you call UnitedHealthcare on June 12th to request a new doctor, the transfer will be effective on July 1st. If you meet the above requirements and you call UnitedHealthcare on June 16th, the transfer will be effective August 1st.

If you wish to transfer out of your Network Medical Group entirely, and you are not an inpatient in a hospital, a Skilled Nursing Facility or other medical institution, receiving radiation or chemotherapy or in the third trimester of pregnancy UnitedHealthcare will approve your request if the PCP within the new Network Medical Group you have chosen is accepting new patients and meets the other criteria in **Section 1. Getting Started**. This includes being located within 30 miles of your Primary Residence or Primary Workplace. The effective date of transfer will be the same as referred to above when requesting a transfer within your Network Medical Group. Some Network Medical Groups only allow new enrollments during the employer's open-enrollment period.

Please Note: UnitedHealthcare does not advise that you change your PCP if you are an inpatient in a hospital, a Skilled Nursing Facility or other medical institution or are undergoing radiation or chemotherapy, as a change may negatively impact your coordination of care. UnitedHealthcare may make exceptions subject to review.

If you wish to transfer out of your Network Medical Group and you are an inpatient in a hospital, a Skilled Nursing Facility or other medical institution, the change will not be effective until the first day of the second month following your discharge from the institution.

If you are pregnant and wish to transfer out of your Network Medical Group and your pregnancy has reached the third trimester, to protect your health and the health of your unborn child, UnitedHealthcare does not permit such change until after delivery of your newborn.

If you change your Network Medical Group, authorizations issued by your previous Network Medical Group will not be accepted by your new group. You should request a new referral from your new PCP within your new Network Medical Group, which may require further review by your new Network Medical Group or UnitedHealthcare.

Please note that your new Network Medical Group or UnitedHealthcare may refer you to a different Provider than the Provider shown on your original authorization from your previous group.

If you are changing Network Medical Groups, UnitedHealthcare may be able to help smooth the transition. When UnitedHealthcare's Case Management is involved, the Case Manager is also consulted about the effective date of your Physician change request. At the time of your request, please let us know if you are

currently under the care of a Specialist, receiving home health care services or using DME such as a wheelchair, walker, hospital bed or an oxygen-delivery system.

When We Change Your Network Medical Group

Under special circumstances, UnitedHealthcare may require that a Member change his or her Network Medical Group. This happens at the request of the Network Medical Group after a material detrimental change in its relationship with a Member. If this happens, we will notify the Member of the effective date of the change, and we will transfer the Member to another Network Medical Group, provided he or she is medically able and there is an alternative Network Medical Group within 30 miles of the Member's Primary Residence or Primary Workplace.

UnitedHealthcare will also notify the Member in the event that the agreement ends between UnitedHealthcare and the Member's Network Medical Group. If this happens, UnitedHealthcare will mail a notice at least 60 days prior to the date of termination. UnitedHealthcare will also assign the Member a new PCP. If the Member would like to choose a different PCP, he or she may do so by calling Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new PCP.

Please Note: Except for Emergency Health Care Services, Urgently Needed Services and those Coverd Health Care Services described under Out-of-Area Services, once an effective date with your new Network Medical Group has been established, a Member must use his or her new PCP or Network Medical Group to authorize all services and treatments. Receiving services elsewhere will result in UnitedHealthcare's denial of benefit coverage.

Continuing Care With a Terminated Provider for Members

Under certain circumstances, you may be eligible to continue receiving care from a terminated Provider to ensure a smooth transition to a new Network Provider and to complete a course of treatment with the same terminated Provider or to maintain the same terminating Provider.

The care must be Medically Necessary, and the cause of Termination by UnitedHealthcare or your Network Medical Group also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

For a Member to continue receiving care from a terminated Provider, the following conditions must be met:

1. A request for Continuity of Care services from a terminated Provider must be submitted to UnitedHealthcare within 30 calendar days from the date your Provider is terminated for review and approval;
2. The requested treatment must be a Covered Health Care Service under this Health Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by UnitedHealthcare or Network Medical Groups/Independent Practice Associations (NMG/IPA) for current Network Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Health Care Services provided by a terminated Provider to a Member who at the time of the Network Provider's contract Termination was receiving services from that Network Provider for one of the Continuity of Care Conditions will be considered complete when:

1. The Member's Continuity of Care Condition under treatment is medically stable, and
2. There are no clinical contraindications that would prevent a medically safe transfer to a Network Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the

terminated Network Provider and, as applicable, the Member's receiving Network Provider.

Continuity of Care also applies to Members who are receiving Mental Health Care Services from a terminated Mental Health Provider, on the effective termination date. Members eligible for continuity of Mental Health Care Services may continue to receive Mental Health Care Services from the terminated Mental Health Provider for a reasonable period of time to safely transition care to a Network Mental Health Provider. Please refer to Medical Benefits and Exclusions and Limitations in **Section 5. Your Medical Benefits** of the UnitedHealthcare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for information. For a description of coverage of mental health care services, please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC.

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 10. Definitions** and believe you qualify for continued care with the terminating Provider, please call UnitedHealthcare and request the form for Continuity of Care Benefits.

Complete and return the form to UnitedHealthcare as soon as possible, but no later than 30 calendar days of the Provider's effective date of termination. Exceptions to the 30-calendar-day time frame will be considered for good cause. The address is:

UnitedHealthcare
Attention: Continuity of Care Department
Mail Stop: CA124-0181
P.O. Box 30968
Salt Lake City, UT 84130-0968
Fax: 1-888-361-0514

UnitedHealthcare's Health Care Services department will complete a clinical review of your Continuity of Care request for Completion of Covered Health Care Services with the terminated Provider and the decision will be made and communicated in a timely manner appropriate for the nature of your medical condition. Decisions for non-urgent requests will be made within five 5 business days of UnitedHealthcare's receipt of the completed form. You will be notified of the decision by telephone, and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two business days of making the decision. If your request for continued care with a terminated Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

If you have any questions, would like a description of UnitedHealthcare's continuity of care process, or want to appeal a denial, please contact UnitedHealthcare.

Please Note: It is not enough to simply prefer receiving treatment from a terminated Physician or other terminated Provider. You should not continue care with a terminated Provider without our formal approval. *If you do not receive Prior Authorization by UnitedHealthcare or your Network Medical Group, payment for routine services performed from a terminated Provider will be your responsibility.*

In the above section Continuity of Care with a terminating Provider, **termination, terminated** or **terminating** references any circumstance which terminates, non-renews or otherwise ends the arrangement by which the Network Provider routinely provides Covered Health Care Services to UnitedHealthcare Members.

SECTION 5. YOUR MEDICAL BENEFITS

- **Inpatient Benefits**
- **Outpatient Benefits**
- **Other Behavioral Health Care Services**
- **Exclusions and Limitations of Benefits**

This section explains your medical benefits, including what is and is not covered by UnitedHealthcare. You can find some helpful definitions in the back of this document. For any Co-payments or Deductibles that may be related to a benefit, you should refer to your Schedule of Benefits, a copy of which is included with this document. UnitedHealthcare's Commercial HMO Benefit Interpretation Policy Manual and Medical Management Guidelines Manual are available at ***www.myuhc.com****.*

I. Inpatient Benefits

THESE BENEFITS ARE PROVIDED WHEN ADMITTED OR AUTHORIZED BY EITHER THE MEMBER'S NETWORK MEDICAL GROUP OR UNITEDHEALTHCARE. THE FACT THAT A PHYSICIAN HAS ORDERED A PARTICULAR SERVICE, SUPPLY OR TREATMENT WILL NOT MAKE IT COVERED UNDER THE HEALTH PLAN. A SERVICE, SUPPLY OR TREATMENT MUST BE MEDICALLY NECESSARY, OR OTHERWISE REQUIRED TO BE COVERED UNDER THE LAW, OR AS OTHERWISE DESCRIBED BELOW AND NOT EXCLUDED FROM COVERAGE IN ORDER TO BE A COVERED HEALTH CARE SERVICE.

With the exception of Emergency Health Care Services or Urgently Needed Services, a Member will only be admitted to acute care and Skilled Nursing Care Facilities that are authorized by the Member's Network Medical Group under contract with UnitedHealthcare.

1. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
2. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a Member and the bone marrow or stem cell services are performed at a Designated Facility. The testing of relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors take place through a registry are covered when the Member is the intended recipient. A Designated Facility center approved by UnitedHealthcare must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor-related clinical transplant services once a donor is identified.
3. **Clinical Trials** – All routine patient care costs incurred during participation in an approved clinical trial for the treatment of:
   - Cancer or other life-threatening disease or condition. For purpose of this benefit, a life-threatening disease or condition is one from which is likely to cause of death unless the course of the disease or condition is interrupted.
   - Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, a clinical trial meets the approved clinical trial criteria stated below.
   - Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, a clinical trial meets the approved clinical trial criteria stated below.
   - Other diseases or disorders which are not life threatening, for which, the clinical trial meets the approved clinical trial criteria stated below.

A Member is considered a Qualified Individual if the Member is eligible to take part in the approved clinical trial according to the trial's protocol and either a Network treating Physician has concluded that the Member's participation in the trial would be appropriate because the Member meets the trial protocol; or the Member self-refers to the trial and has provided medical and scientific information to establish that participation in the trial is consistent with the trial protocol.

For the purposes of this benefit, Network treating Physician means a Physician who is treating a Member as a Network Provider according to an authorization or referral from the Member's Network Medical Group or UnitedHealthcare.

Routine patient care costs for qualifying clinical trials include drugs, items, devices and services provided consistent with coverage under the Agreement for a member who is not enrolled in an approved clinical trial, including:

- Drugs, items, devices, and services for which Benefits are typically provided absent a clinical trial.
- Drugs, items, devices, and services required solely for the following:
    - The provision of the Experimental or Investigational drug, item, device, or service.
    - The clinically appropriate monitoring of the effects of the Experimental or Investigational, drug, item, device, or service .
    - The prevention of complications arising from the provision of the Experimental or Investigational drug, item, device, or service.
- Drugs, items, devices, and services needed for reasonable and necessary care arising from the provision of the Investigational drug item, device, or service, including the diagnosis and treatment of complications.

For purposes of this benefit, routine patient care costs do not include the costs related to any of the following, which are not covered by UnitedHealthcare:

- The Experimental or Investigational drug service(s), device or item. The only exceptions to this are:
    - Certain *Category B* devices.
    - Certain promising interventions for patients with terminal illnesses. Certain promising interventions refer to treatment that is likely safe but where limited to and/or conflicting evidence exists regarding its effectiveness.
    - Other items and services that meet specified criteria in agreement with our medical and drug policies.
- Drugs, items, devices, and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices and services required to be covered pursuant to applicable law.
- Drugs, items, devices and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or conditions, including involving a drug that is exempt under federal regulations from a new drug application. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, an approved clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - National Institutes of Health (NIH). (Includes *National Cancer Institute (NCI)*.)
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - A cooperative group or center of any of the entities described above or the United States Department of Defense (DOD) or the Veterans Affairs (VA);
    - A qualified non-governmental research entity shown in the guidelines issued by the National Institutes of Health for center support grants.
    - The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
        - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
        - Ensures unbiased review of the highest scientific standards by qualified persons who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration;*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;

A clinical trial with endpoints defined exclusively to test toxicity is not an approved clinical trial.

All services must have Prior Authorization from UnitedHealthcare's Medical Director or designee. Additionally, services must be provided by a UnitedHealthcare Network Provider in UnitedHealthcare's Service Area. In the event a UnitedHealthcare Network Provider does not offer a clinical trial with the same protocol as the one the Member's Network treating Physician recommended, the Member may choose a Provider performing a clinical trial with that protocol within the State of California. If there is no Provider offering the clinical trial with the same protocol as the one the Member's treating Network Physician recommended in California, the Member may choose a clinical trial outside the State of California but within the United States of America.

UnitedHealthcare is required to pay for the services covered under this benefit at the rate agreed upon by UnitedHealthcare and a Network Provider, minus any applicable Co-payment or Deductibles. In the event the Member takes part in a clinical trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, the Member will be responsible for payment of the difference between the Out-of-Network Provider's billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payment or Deductibles.

Any additional expenses the Member may have to pay beyond UnitedHealthcare's negotiated rate due to using an Out-of-Network Provider do not apply to the Member's Annual Co-payment Limit.

4. **Gender Dysphoria -** Prior authorization of medically necessary services must be done by UnitedHealthcare or delegated Providers as determined by UnitedHealthcare. For more information regarding this coverage, please refer to the Benefit Interpretation Policy Manual and Medical Management Guidelines Manual available at **www.myuhc.com**.

5. **Hospice Services** – Hospice services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided as determined by the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's PCP, a registered nurse, a social worker and a spiritual caregiver. Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

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

   Inpatient Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is needed to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

6. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary inpatient Hospital Services authorized by the Member's Network Medical Group or UnitedHealthcare are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, or other professionals as authorized under California law, intensive care, operating room, recovery room, laboratory and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for Medically Necessary care and treatment.

7. **Inpatient Hospital Mental Health Care Services –** Medically Necessary Inpatient Hospital Services, listed below to treat Mental Health Disorders are covered under this Health Plan and are provided to you by USBHPC. Mental Health Care Services for the diagnosis and treatment of Mental Health Disorders.

   - Inpatient Mental Health Care Services – psychiatric inpatient services, including room and board, drugs and services, including psychiatric inpatient services from licensed mental health Providers including but not limited to psychiatrists and psychologists, provided at an Inpatient Treatment Center, Residential Treatment Center are covered when Medically Necessary, Prior Authorized by USBHPC, and provided at a Network Facility.
   - Inpatient Physician Services – Medically Necessary inpatient psychiatric services, including voluntary psychiatric inpatient services provided by a Network Practitioner acting within the scope of their license while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Network Residential Treatment Center and which have been Prior Authorized by USBHPC.

   See your behavioral health supplment to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC as to how to obtain prior authorization and for any other further information.

   See your *Schedule of Benefits* for any amounts you may have to pay.

8. **Inpatient Physician and Specialist Care** – Services from Physicians, including Specialists and other licensed health professionals within, or upon referral from, the Member's Network Medical Group are covered while the Member is hospitalized as an inpatient. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.

9. **Inpatient Rehabilitation and Habilitation Care** – Rehabilitation and Habilitation Services that must be provided in an inpatient rehabilitation/habilitation Facility are covered. Inpatient rehabilitation/habilitation consists of the combined and coordinated use of physical, occupational, and speech therapy when Medically Necessary and provided by a Network Provider who is a registered physical, speech or occupational therapist, or a healthcare professional under the direct supervision of a licensed physical therapist acting within the scope of his or her license under California law. Medically Necessary treatment for Mental Health Disorders and Substance-Related and Addictive Disorders are covered. (For a description of coverage of Mental Health Disorder and Substance-Related and Addictive Disorders, please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*.)

10. **Inpatient Substance-Related and Addictive Disorder Services –** Medically Necessary hospitalization for services to treat Substance-Related and Addictive Disorder listed below are covered and are provided to you by USBHPC.

    - Inpatient Substance-Related and Addictive Disorder Services, including Medical Detoxification provided at an Inpatient Treatment Center – Medically Necessary Substance-Related and Addictive Disorder Services, including Medical Detoxification, which have been Prior Authorized by USBHPC and are provided by a Network Practitioner while the Member is confined in a Network Inpatient Treatment Center or at a Network Residential Treatment Center.
    - Inpatient Physician Care – Medically Necessary Substance-Related and Addictive Disorder Services, including Medical Detoxification, provided by a Network Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Network Day Treatment Center and which have been Prior Authorized by USBHPC.
    - Medical Detoxification – Medical Detoxification services, including room and board, drugs, dependency recovery services, education and counseling are covered when provided by a Network Practitioner at a Network Inpatient Treatment Center or at a Residential Treatment Center when Prior Authorized by USBHPC.
    - Substance-Related and Addictive Disorder Services including Transitional Residential Recovery Services Rendered at a Residential Treatment Center – Medically Necessary Substance-Related and Addictive Disorder Services, provided to a Member during confinement at a Network Residential Treatment Center are covered, if provided or prescribed by a Network Practitioner and Prior Authorized by USBHPC.

    See your behavioral health supplment to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC as to how to obtain prior authorization and for any other further information.

    See your *Schedule of Benefits* for any amounts you may have to pay.

11. **Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy** – Medically Necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending Physician and surgeon, in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is needed to achieve

symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

12. **Maternity Care** – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section, treatment of miscarriage and complications of pregnancy or childbirth. Certain prenatal services are covered as preventive care. Please refer to Preventive Care Services in the outpatient benefits section.

    - Educational courses on childcare and/or prepared childbirth classes are not covered.
    - Alternative birthing center services are covered when provided or arranged by a Network Hospital affiliated with the Member's Network Medical Group.
    - Licensed/Certified nurse midwife services are covered only when available within the Member's Network Medical Group.
    - Elective home deliveries are not covered.

    A minimum 48 hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48 or 96 hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

    Maternal mental health condition including but not limited to prenatal or postpartum screening for maternal mental health conditions by a licensed health care practitioner who provides prenatal or postpartum care for a patient is covered. "Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

13. **Morbid Obesity (Surgical Treatment)** – Bariatric surgical procedures are covered when Medically Necessary and Prior Authorized. We will use evidence-based criteria to determine coverage of bariatric surgery, such as the most recent National Institutes of Health (NIH) guidelines, in determining the Medical Necessity of requests for surgical treatment for morbid obesity. Please refer to your *Schedule of Benefits* for Co-payment/Deductible information of this benefit or you may call UnitedHealthcare for additional information.

14. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision and special care nursery. A newborn Co-payment applies in addition to the Co-payment for maternity care, unless the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or within 96 hours of the baby's cesarean delivery. Circumcision is covered for male newborns prior to hospital discharge. See Circumcision under Outpatient Benefits for an explanation of coverage after hospital discharge.

15. **Organ Transplant and Transplant Services** – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a Designated Facility. Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency is the same for both facilities.

    Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, UnitedHealthcare will only cover costs related to the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the facility where the transplant is performed. The Member will be responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second facility. Covered Health Care Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other non-clinical

expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for Designated Facility.)

16. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include a cleft palate, cleft lip, or other craniofacial anomalies related with a cleft palate. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Prior Authorization by the Member's Network Medical Group or UnitedHealthcare in agreement with standards of care as practiced by Physicians specializing in reconstructive surgery.
17. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Care and Skilled Rehabilitation and Habilitation Care are covered. The Member's Network Medical Group or UnitedHealthcare will determine where the Skilled Nursing Care and Skilled Rehabilitation and Habilitation Care will be provided. Refer to your *Schedule of Benefits* for the number of days covered under your Health Plan. Subacute and Transitional Care are levels of care provided by a Skilled Nursing Facility to a Member who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Facility care than is provided to the majority of the patients in a Skilled Nursing Facility.

    Skilled Nursing Facility services will be provided in place of a Hospital stay when Medically Necessary, and when authorized by the Member's PCP, or by the Member's Network Medical Group or by UnitedHealthcare. When the Member is transferred from a Skilled Nursing Facility to an acute Hospital setting, and then back to a Skilled Nursing Facility, the days spent in the acute Hospital are not counted against the benefit limitation as described in your *Schedule of Benefits*.

    A benefit period begins on the date the enrollee is admitted to a Hospital or a Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care Hospital is not required to begin a benefit period.

    Prescription drugs are covered when provided by the Skilled Nursing Facility and used by the Member during a period of covered Skilled Nursing Facility care. Services or supplies not included in the written treatment plan and Custodial Care are not covered.

    Outpatient drugs and prescription medications are available as a supplemental benefit. Please refer to "Drugs and Prescription Medication" (Outpatient) listed in Exclusions and Limitations.

18. **Termination of Pregnancy** – Refer to the *Schedule of Benefits* for the terms of coverage.

II. Outpatient Benefits

The following benefits are available on an outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Network Medical Group or UnitedHealthcare. The fact that a Physician has ordered a particular service, supply or treatment will not make it covered under the Health Plan. A service, supply or treatment must be Medically Necessary, or otherwise required to be covered under the law or as otherwise described below and not excluded from coverage in order to be a Covered Health Care Service.

1. **Acupuncture** – Acupuncture services (typically covered only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.) Please refer to your *Schedule of Benefits.*

2. **Allergy Serum** – Allergy serum, including needles, syringes, and other supplies for the administration of the serum, are covered for the treatment of allergies. Allergy serum, needles and syringes must be obtained through a UnitedHealthcare Network Physician.
3. **Allergy Testing Treatment** – Services and supplies are covered, including provocative antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy and serum, are covered according to an established treatment plan.
4. **Ambulance** – The use of an ambulance (land or air) is covered without Prior Authorization when the Member reasonably believes there is an emergency medical or psychiatric condition that requires ambulance transport to access Emergency Health Care Services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-Emergency Health Care Services is covered only when it is authorized by the Member's Network Medical Group or UnitedHealthcare.
5. **Attention Deficit/Hyperactivity Disorder** – The medical management of Attention Deficit/ Hyperactivity Disorder (ADHD) is covered, including the diagnostic evaluation and laboratory monitoring of prescribed drugs. This medical benefit does not include family counseling, please refer to **Section 5. Your Medical Benefits** and to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for USBHPC for terms and conditions of coverage.
6. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
7. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is covered only when the Member has either of the following:

   a. Craniofacial anomalies in which abnormal or absent ear canals prevent the use of a wearable hearing aid, or

   b. Hearing loss of sufficient severity that it cannot be corrected by a wearable hearing aid.

   Covered Health Care Services are available for a bone anchored hearing aid that is purchased as a result of a written recommendation by a Network Physician.

   Note: Bone-anchored hearing aid will **not** be subject to the nonimplantable hearing aid limit. There will not be a dollar maximum related to this benefit. Bone-anchored hearing aid will be subject to applicable medical/surgical categories (e.g., inpatient hospital, Physician fees) only for Members who meet the medical criteria shown above. Repairs and/or replacement for the implanted components of a bone-anchored hearing aid are not covered, except for malfunctions.

   Replacement of external hearing aid components for bone-anchored hearing aids is covered under the DME benefit. External components for bone-anchored hearing aids are either body-worn or worn behind the ear. Examples of external components include an external abutment and a sound processor. Replacement of external hearing aid components is only covered due to malfunction and when the condition of the device or part requires repairs that exceed the cost of replacement. Deluxe model and upgrades that are not Medically Necessary are not covered.

   Please refer to the "Hearing Aid and Hearing Device" benefit description in this section for non-implantable hearing aid; the *Schedule of Benefits* for applicable Co-payments/Deductibles and to the "Bone-Anchored Hearing Aid" exclusion listed in "Other Exclusions and Limitations".
8. **Chiropractic Services –** Please refer to your *Chiropractic Schedule of Benefits*, if any.

9. **Clinical Trials** – Please refer to the benefit described above under Inpatient Clinical Trials. Outpatient services Co-payments and/or Deductibles apply for any Clinical Trials services received on an outpatient basis according to the Co-payments for that specific outpatient service. UnitedHealthcare is required to pay for the services covered under this benefit at the rate agreed upon by UnitedHealthcare and a Network Provider, minus any applicable Co-payment or Deductibles. In the event the Member takes part in a clinical trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, the Member will be responsible for payment of the difference between the Out-of-Network Provider's billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payment, or Deductibles.

   Any additional expenses the Member may have to pay beyond UnitedHealthcare's negotiated rate due to using an Out-of-Network Provider do not apply to the Member's Annual Co-payment Limit.

10. **Circumcision** – Circumcision is covered for male newborns prior to hospital discharge. Circumcision is covered after hospital discharge only when:

    - Circumcision was delayed by the Network Provider during first hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the 28 day neonatal period, or
    - Circumcision was determined to be medically inappropriate during first hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.). The circumcision is covered when the Network Provider determines it is medically safe and the circumcision is performed within 90 days from that determination.
    - Circumcision other than noted under the outpatient Circumcision benefit will be reviewed for Medical Necessity by the Network Medical Group or UnitedHealthcare Medical Director or designee.

11. **Cochlear Implant Device** – An implantable cochlear device for bilateral, profoundly hearing-impaired persons or prelingual persons who are not benefited from conventional amplification (hearing aids) is covered. Please also refer to "Cochlear Implant Medical and Surgical Services".

12. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing-impaired or prelingual persons who are not benefited from hearing aids is covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Network Provider. (For an explanation of speech therapy benefits, please refer to Outpatient Medical Rehabilitation and Habilitation Therapy.)

13. **Dental Treatment Anesthesia** – See Oral Surgery and Dental Services; Dental Treatment Anesthesia.

14. **Diabetic Management and Treatment** – Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Network Provider.

15. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to help the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; podiatry services; and devices to prevent or treat diabetes-related complications. Members must have coverage under the Outpatient Prescription Drug Benefit Supplement for insulin, glucagon and other diabetic medications.

Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses or contact lenses. The Member's Network Provider will prescribe insulin syringes and pen delivery systems, lancets and lancet puncture devices, blood glucose test strips and ketone urine test strips to be filled at a pharmacy that contracts with UnitedHealthcare.

16. **Dialysis** – Acute and chronic hemodialysis and peritoneal dialysis services and supplies are covered. Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's Network Medical Group or UnitedHealthcare and provided within the Member's Network Medical Group. The fact that the Member is outside the geographic area served by the Network Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

17. **Drug and Prescription Medications** – Prescribed medications are covered as described in the Outpatient Prescription Drug Benefit Supplement to this *Evidence of Coverage.*

18. **Durable Medical Equipment (DME) (Rental, Purchase or Repair)** – DME is covered when it is designed to help in the treatment of an injury or illness of the Member, and the equipment is mainly for use in the home (or another location used as the enrollee's home). DME is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered DME include wheelchairs, hospital beds, standard oxygen-delivery systems, equipment for the treatment of asthma (nebulizers, masks, tubing and peak flow meters, the equipment and supplies must be prescribed by and are limited to the amount requested by the Network Physician), standard curved handle or quad cane and replacement supplies, standard or forearm crutches and replacement supplies, dry pressure pad for a mattress, IV pole, enteral pump and supplies, bone stimulator, cervical traction (over the door), phototherapy blankets for treatment of jaundice in newborns, certain dialysis care equipment, brassieres required to hold a breast prosthesis (up to three every 12 months), compression burn garments and lymphedema wraps and garments dialysis equipment and supplies for home hemodialysis and peritoneal dialysis. Outpatient drugs, prescription medications and inhaler spacers for the treatment of asthma are available under the prescription drug benefit. Please refer to the *Pharmacy Schedule of Benefits*, Medication Covered By Your Benefit under "Miscellaneous Prescription Drug Coverage" for coverage.

    Ostomy and urological supplies substantially equal to the following:

    a. Ostomy supplies: adhesives; adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape.

    b. Urological supplies: adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.

    c. Incontinence supplies for Hospice patients: disposable incontinence underpads; adult incontinence garments.

    d. Ostomy and urological supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.

Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Network Medical Group or UnitedHealthcare has the option to repair or replace DME items. Replacement of lost or stolen DME is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to accomidate the Member's condition.

For a detailed listing of covered DME, please contact UnitedHealthcare at 1-800-624-8822.

Please refer to Bone-Anchored Hearing Aid in the Outpatient Benefits section and in the Other Exclusions and Limitations section for a description of coverage for external hearing aid components subject to the DME benefit and limitations.

19. **Enteral Formula** – Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

    - Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
    - Severe food allergies.
    - Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

    Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

    For the purpose of this Benefit, "enteral formulas" include:

    - Amino acid-based elemental formulas.
    - Extensively hydrolyzed protein formulas.
    - Modified nutrient content formulas.

    For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

    - Malnourishment;
    - Chronic physical disability;
    - Intellectual disability; or
    - Loss of life.

20. **Family Planning** – Covered Health Care Services include all Food and Drug Administration (FDA) approved contraceptive methods including drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the Member's Network Provider, voluntary sterilization procedures, and patient education and counseling on contraception and follow-up services related to the drugs, devices, products, and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

    Where FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, we are only required to cover at least one therapeutic equivalent without cost sharing. If a contraceptive is prescribed for other than contraceptive purposes, the Co-payment or Deductible at the applicable prescription drug tier will apply.

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

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

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

    Benefits are not available for embryo transfer.

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

22. **Footwear** – Prescribed by a Physician, surgeon, or doctor of podiatric medicine and professional services provided by a certified orthotist or certified prosthetist, custom orthotic devices required to support or correct a defective body part and custom orthotic devices for Members suffering from foot disfigurement caused by, but not limited to, cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, developmental disability or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Network Medical Group or UnitedHealthcare. The services must be Prior Authorized by the Member's Network Medical Group or UnitedHealthcare for benefit eligibility.

23. **Gender Dysphoria -** Prior authorization of medically necessary services must be done by UnitedHealthcare or delegated Providers as determined by UnitedHealthcare. For more information regarding this coverage, please refer to the Benefit Interpretation Policy Manual and Medical Management Guidelines Manual available at **www.myuhc.com**.

24. **Health Education Services** – Includes wellness programs such as a stop smoking or tobacco cessation program available to enrolled Members. UnitedHealthcare also makes health and wellness information available to Members. For more information about the tobacco cessation program or any other wellness program, contact UnitedHealthcare at 1-800-624-8822, or at www.myuhc.com.

    The Member's Network Medical Group may offer additional community health programs. These programs are independent of health improvement programs offered by UnitedHealthcare and are not covered. Fees charged will not apply to the Member's Co-payment limit.

25. **Hearing Aids and Hearing Devices/ Exams** – Hearing aids required for the correction of a hearing impairment, a reduction in the ability to perceive sound which may range from slight to complete deafness are covered. Hearing aids are electronic amplifying devices designated to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

    Covered Health Care Services are available for a hearing aid that is purchased due to a written recommendation by a Network Physician. Covered Health Care Services are provided for the hearing aid and for charges for associated fitting and testing.

    Nonimplantable hearing aid benefit will be limited to one hearing aid including repairs and replacements per hearing impaired ear every three years.

Please refer to the *Schedule of Benefits* for any applicable Co-payments, and Deductible Amounts limit and benefit limitations in the Hearing Aid and Hearing Device listed in Other Exclusions and Limitations. For implantable hearing aid, refer to Bone-Anchored Hearing Aid in this section.

Please refer to the *Schedule of Benefits* for applicable Co-payments for Hearing Exams, if covered.

26. **Home Health Care Visits** – A Member is eligible to receive Home Health Care Visits if the Member:

- is confined to the home (home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities);
- needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and
- the Home Health Care Visits are provided under a plan of care established and periodically reviewed and ordered by a UnitedHealthcare Network Provider. “Skilled Nursing Services” means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse.

If a Member is eligible for Home Health Care Visits in agreement with the authorized treatment plan, the following Medically Necessary Home Health Care Visits may be included, but are not limited to:

a. Skilled nursing visits;

b. Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the Member’s illness or injury;

c. Physical, occupational, or speech therapy that is provided on a per visit basis;

d. Medical supplies, DME;

e. Infusion therapy medications and supplies and laboratory services as prescribed by a Network Provider to the extent such services would be covered by UnitedHealthcare had the Member remained in the hospital, rehabilitation or Skilled Nursing Facility;

f. Drugs, medications and related pharmaceutical services are covered for those Members enrolled in UnitedHealthcare’s Outpatient Prescription Benefit. Outpatient prescription drugs are available as a supplemental benefit. Please refer to your *Schedule of Benefits*.

If the Member’s Network Medical Group determines that Skilled Nursing Care needs are more extensive than the services described in this benefit, the Member will be transferred to a Skilled Nursing Facility to obtain services. UnitedHealthcare, in consultation with the Member’s Network Medical Group, will determine the appropriate setting for delivery of the Member’s Skilled Nursing Services.

Please refer to the *Schedule of Benefits* for any applicable Co-payments/Deductibles and benefit limitations.

27. **Home Test Kits for Sexually Transmitted Diseases**

Benefits for home test kits for sexually transmitted diseases (STDs), including any laboratory costs for processing the kit, that are Medically Necessary or appropriate and ordered directly by a Network provider, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

"Home test kit" means a product used for a test recommended by the federal *Centers for Disease Control and Prevention* guidelines or the *United States Preventive Services Task Force* that has been waived under the federal *Clinical Laboratory Improvement Act* (*CLIA*), *FDA*-cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

28. **Hospice Services** – Hospice services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided according to the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's PCP, a registered nurse, a social worker and a spiritual caregiver.

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

    Covered Hospice services are available in the home on a 24 hour basis when Medically Necessary, during periods of crisis, when a Member requires continuous care to achieve palliation or management of acute medical symptoms. Inpatient Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is needed to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

29. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any. Coverage for Infertility services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. If the Member's Health Plan includes an Infertility services supplemental benefit, a supplement to the *Combined Evidence of Coverage and Disclosure Form* will be provided to the Member.

30. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** –

    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route (includes chemotherapy). Infusion therapy is covered when provided as part of a treatment plan authorized by the Member's PCP, Network Medical Group or UnitedHealthcare. The infusions must be administered in the Member's home, Network Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living facility, which is not a hospital or institution mainly engaged in providing Skilled Nursing Care or Rehabilitation Services.
    - **Outpatient Injectable Medications** – Outpatient injectable medications (except insulin) include those drugs or preparations which are not usually self-administered, and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as part of a Physician's office visit and when not otherwise limited or excluded (e.g., insulin, certain immunizations, infertility drugs, birth control, or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Network Provider, the Member's Network Medical Group or UnitedHealthcare-Designated Pharmacy and may require Prior Authorization by UnitedHealthcare. Please refer to Preventive Care Services in the *Outpatient Benefits* section for a description of immunizations covered as preventive care.
    - **Self-Injectable Medications** – Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by the Subcutaneous route regardless of the frequency of administration, or by the Intramuscular route at a frequency of one or more times per week. Self-injectable medications (except insulin) are covered when prescribed by a Network Provider, as authorized by the Member's Network Medical Group or by UnitedHealthcare. Self-injectable medications must be obtained through a Network Provider, through the Member's Network Medical Group or UnitedHealthcare-Designated Pharmacy/specialty injectable vendor and

- may require Prior Authorization by UnitedHealthcare. A separate Co-payment applies to all self-injectable medications for a 30 day supply (or for the prescribed course of treatment if shorter), whether self-administered or injected in the Physician's office, and is applied in addition to any office visit Co-payment or Deductible.

31. **Laboratory Services** – Medically Necessary diagnostic and therapeutic laboratory services are covered.

32. **Maternity Care, Tests and Procedures/ Maternal Mental Health** – Physician visits, laboratory services (including the California Prenatal Screening Program), and radiology services are covered for prenatal and postpartum maternity care. Nurse-midwife services are covered when available within, and authorized by, the Member's Network Medical Group.

    Prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available are covered.

    When certain laboratory services are performed as prenatal preventive screening, as defined by the United Services Preventive Services Task Force (USPSTF) with an A or B recommendation and the Department of Health and Human Services (HHS). Covered Health Care Services are provided under *Preventive Care Services* in the *Outpatient Benefits* section.

    Maternal mental health condition including but not limited to prenatal or postpartum screening for maternal mental health conditions by a licensed health care practitioner who provides prenatal or postpartum care for a patient is covered. "Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

33. **Medical Supplies and Materials** – Medical supplies and materials needed to treat an illness or injury are covered when used or provided while the Member is treated in the Network Provider's office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Network Provider. Examples of items commonly provided in the Network Provider's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts.

34. **Mental Health Services –** services for the prevention, diagnosis and treatment of mental health and substance use disorders. Mental health and substance use disorders are defined as a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

    Outpatient Mental Health Care Services – Medically Necessary Mental Health Care Services provided by a network practitioner including individual and group mental health evaluation and treatment and services for the purpose of monitoring drug therapy. Certain outpatient services that require Prior Authorization by USBHPC, when Medically Necessary are Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*. Such services must be provided at the office of the network practitioner or at a network outpatient treatment center. Intensive psychiatric treatment programs may include Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment as intensive outpatient care.

    Benefits include Behavioral Health Treatment for Autism Spectrum Disorders under the same terms and conditions that apply to medical conditions. Medically Necessary Behavioral Health Treatment will not be denied or unreasonably delayed:

    - Based on an asserted need for cognitive or intelligence quotient (IQ) testing;

- On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or
- On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

Psychiatric observation for an acute psychiatric crisis.

Prescribed medications are covered as described in the *Outpatient Prescription Drug Benefit* supplement to this *Combined Evidence of Coverage and Disclosure Form*.

See your *Schedule of Benefits* for for any amounts including Co-payments and Deductibles you may have to pay.

For utilization review criteria, education programs and training materials relating to Mental Health Care and Substance-Related and Addictive Disorder Services contact us at www.myuhc.com or the telephone number on your ID card. Utilization review criteria, education programs and training materials relating to Mental Health Care and Substance-Related and Addictive Disorder Services will be provided at no cost to Members.

See Substance-Related and Addictive Disorder Services for services provided.

35. **OB/GYN Physician Care** – See Physician OB/GYN Care.
36. **Oral Surgery and Dental Services** – Emergency Health Care Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable. Other covered oral surgery and dental services include:

    Oral surgery or dental services, provided by a Physician or dental professional for treatment of primary medical conditions. Examples include, but are not limited to:

    - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ);
    - Biopsy of gums or soft palate;
    - Oral or dental exam performed on an inpatient or outpatient basis as part of a comprehensive work-up prior to transplantation surgery;
    - Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
    - Reconstruction of a ridge that is performed as a result of, and at the same time as, the surgical removal of a tumor (for other than dental purposes);
    - Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
    - Reconstructive surgery due to congenital defect such as cleft lip and cleft palate. Refer to *Reconstructive Surgery* in this section.
    - Ridge augmentation or alveoplasty are covered when determined to be Medically Necessary based on state cosmetic reconstructive surgery law and jawbone surgery law;
    - Setting of the jaw or facial bones;
    - Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;

- Treatment of maxillofacial cysts, including extraction and biopsy.

Dental Services beyond emergency treatment to stabilize an acute injury – including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures – are not covered. Please refer to the Dental Supplement to the *Combined Evidence of Coverage and Disclosure Form* for additional pediatric dental benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, dental services include those for crowns, root canals, replacement of teeth, complete dentures, gold inlays, fillings, and other dental services specific to the replacement of teeth or structures directly supporting the teeth and other dental services specific to the treatment of the teeth, are not covered except for services covered by UnitedHealthcare under this outpatient benefit, Oral Surgery and Dental Services.

37. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Anesthesia and related Facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when:

    A. The Member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting; and

    B. One of the following criteria is met:

        - The Member is under seven years of age;
        - The Member is developmentally disabled, regardless of age; or
        - The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

    The Member's dentist must get Prior Authorization from the Member's Network Medical Group or UnitedHealthcare before the dental procedure is provided.

    Dental anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, are not covered except for services covered by UnitedHealthcare under the outpatient benefit, Oral Surgery and Dental Services. Please refer to the Dental Supplement to the *Combined Evidence of Coverage and Disclosure Form* for additional pediatric dental benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.

38. **Outpatient Habilitative Services and Devices–** For purposes of this benefit, habilitative services means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

    Services include:

    - Individual and group outpatient physical, occupational, and speech therapy related to Autism Spectrum Disorder.
    - All other individual and group outpatient physical, occupational, and speech therapy.
    - Cognitive habilitation therapy
    - Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

Habilitative services must be performed by a Physician, a licensed therapy Provider, or qualified autism service Provider or other Provider licenses, certified, or otherwise authorized under state law to perform the service, and within the Provider's scope of practice. Benefits under this section include habilitative services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Habilitative services provided in a Member's home by a home health agency are provided as described under *Home Health Care Visits*. Habilitative services provided in a Member's home other than by a home health agency are provided as described under this section.

Benefits can be discontinued when the treatment goals and objectives are achieved or no longer appropriate.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment (Rental, Purchase or Repair)* and *Prosthetics and Corrective Appliances/Orthotics*.

Benefits for habilitative services provided during an Inpatient Stay are a medical benefit as described under *Skilled Nursing Facility/Subacute Transitional Care* and *Inpatient Rehabilitation and Habilitation Care*.

Benefits, terms, and conditions for behavioral health treatment for Autism Spectrum Disorder are described under *Inpatient Mental Health Services* and *Outpatient Mental Health Services.*

39. **Outpatient Rehabilitation Services and Devices** - Services include:

- Individual and group outpatient physical, occupational, and speech therapy related to Autism Spectrum Disorder.
- All other individual and group outpatient physical, occupational, and speech therapy.
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation
- Post-cochlear implant aural therapy
- Cognitive rehabilitation therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

Rehabilitation services must be performed by a Physician, a licensed therapy Provider, or qualified autism service Provider or other Provider licenses, certified, or otherwise authorized under state law to perform the service, and within the Provider's scope of practice. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Member's home by a home health agency are provided as described under *Home Health Care Visits*. Rehabilitative services provided in a Member's home other than by a home health agency are provided as described under this section.

Benefits can be discontinued when the treatment goals and objectives are achieved or no longer appropriate.

Benefits for inpatient rehabilitative services provided during an Inpatient Stay are a medical benefit as described under *Skilled Nursing Facility/Subacute Transitional Care* and *Inpatient Rehabilitation and Habilitation Care*.

Benefits, terms, and conditions for behavioral health treatment for Autism Spectrum Disorder are described under *Inpatient Mental Health Services and Outpatient Mental Health Services.*

40. **Outpatient Services** – Medically Necessary services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory

surgical center or outpatient surgery department of an acute hospital are covered. Examples include, but are not limited to: endoscopies, hyperbaric oxygen and wound care.

41. **Outpatient Surgery** – Short-stay, same-day or other similar outpatient surgery facilities and professional Physician/ surgeon fees and outpatient visits are covered.
42. **Physician Care (PCP and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's PCP are covered. Services of a Specialist are covered upon referral by Member's Network Medical Group or UnitedHealthcare. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
43. **Physician OB/GYN Care** – The Member may get obstetrical and gynecological Physician services directly from an OB/GYN, Family Practice Physician or surgeon (designated by the Member's Network Medical Group as providing OB/GYN services) affiliated with the Member's Network Medical Group.
44. **Preimplantation Genetic Testing (PGT) and Related Services**

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

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

    Benefits are not available for long-term storage costs (greater than one year).
45. **Preventive Care Services** – Preventive Care Services means Covered Health Care Services provided on an outpatient basis at a Network Physician's office or a Network Hospital that encompasses medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to be related to beneficial health outcomes and include the following as required under applicable law:
    - Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
    - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.
    - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*, including well-woman visits (including routine prenatal obstetrical office visits); gestational diabetes screening;

- human papillomavirus (HPV) DNA testing for women 30 years and older every 3 years; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus (HIV); breastfeeding support and counseling; breast pump purchase of personal pump and supplies; and screening and counseling for interpersonal and domestic violence.

  All *Food and Drug Administration (FDA)* approved contraceptive methods including drugs, devices, and other products, including all *FDA*-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the Member's Network Provider, voluntary sterilization procedures, and patient education and counseling on contraception and follow-up services related to the drugs, devices, products, and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

  Where *FDA* has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, we are only required to cover at least one therapeutic equivalent without cost sharing. If a contraceptive is prescribed for other than contraceptive purposes, the Co-payment at the applicable prescription drug tier will apply.

Preventive screening services include but are not limited to the following:

- **Adverse Childhood Experiences Screening** – Routine screening for adverse childhood experiences.
- **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's PCP. Mammography for screening or diagnostic purposes is covered as authorized by the Member's Network nurse practitioner, Network nurse midwife or Network Provider.
- **Colorectal Screening** – Routine screening beginning at age 50 for men and women at average risk with interval determined by method. Potential screening options include home Fecal Occult Blood test (FOBT), flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, or double-contrast barium enema or a colonoscopy for a positive result on a test or procedure, other than a colonoscopy.
- **Hearing Screening** – Routine hearing screening by a Network health professional is covered to determine the need for hearing correction. Hearing screening tests for Members are covered in agreement with American Academy of Pediatrics (Bright Futures) recommendations.
- **Human Immunodeficiency Virus (HIV)** – Services for human immunodeficiency virus (HIV) testing, regardless whether the testing is related to a primary diagnosis.
- **Newborn Testing** – Covered tests include, but are not limited to, phenylketonuria (PKU), Sickle cell disease, and congenital hypothyroidism.
- **Prostate Screening** – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These screenings are provided when consistent with good professional practice.
- **Tobacco Screening** – Routine screening of tobacco use. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
  - Four Tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
  - All *Food and Drug Administration (FDA)*-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment plan when prescribed by a health care Provider without prior authorization. Please refer to the

- Outpatient Prescription Drug Benefit Supplement to the Combined Evidence of Coverage and Disclosure Form for the covered tobacco cessation drugs (both over-the-counter and prescription).
- Tobacco cessation medications (both over-the-counter and prescription) covered at zero cost share when prescribed and prior authorized. In addition, you must take part in tobacco cessation counseling sessions as described above. Please call Customer Service for more information.

- **Vision Screening** – Annual routine eye health assessment and screening by a Network Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal exam is covered for Members with diabetes.
- **Well-Baby/Child Adolescent Care** –Preventive health care services are covered (including immunizations) when provided by the child's Network Medical Group.
- **Well-Woman Care** – Medically Necessary obstetrical and gynecological services, including a Pap smear (cytology) and routine prenatal obstetrical office visits are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or Family Practice Physician or surgeon (designated by the Member's Network Medical Group as providing OB/GYN services) affiliated with Member's Network Medical Group.

46. **Prosthetics and Corrective Appliances/Orthotics** – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the Member's Network Medical Group or UnitedHealthcare. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include the first contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue, prostheses to replace all or part of an external facial body part that has been removed or impaired due to disease, injury, or congenital defect.

    Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether the enrollee needs a prosthetic or orthotic device.

    Custom-made or custom-fitted corrective appliances/ orthotics are covered when Medically Necessary as determined by the Member's Network Medical Group or UnitedHealthcare. Corrective appliances/ orthotics are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual Member.

    - Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics are not covered.
    - Deluxe upgrades that are not Medically Necessary are not covered.
    - Replacements, repairs and adjustments to both corrective appliances/ orthotics and prosthetics are covered when Medically Necessary. Repair or replacement must be authorized by the Member's Network Medical Group or UnitedHealthcare.
    - An artificial larynx or electronic speech aid is covered post-laryngectomy or for a Member with permanently inoperative larynx condition.

    Refer to Footwear in Outpatient Benefits and Foot Orthotics/Footwear in Other Exclusions and Limitations.

    For a detailed listing of covered DME, and prosthetic and corrective appliances, please call our Customer Service department at 1-800-624-8822.

47. **Radiation Therapy (Standard and Complex)** –

    - Standard photon beam radiation therapy is covered.

- Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation and IMRT. Gamma knife procedures and stereotactic radiosurgery procedures are covered as outpatient surgeries for the purpose of determining Co-payments or Deductibles. (Please refer to your *Schedule of Benefits* for applicable Co-payment/Deductible, if any.)

48. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an important part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies related with cleft palate. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Prior Authorization by the Member's Network Medical Group or UnitedHealthcare in agreement with standards of care as practiced by Physicians specializing in reconstructive surgery.

49. **Refractions** – Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if the Member's Health Plan includes a supplemental vision benefit.) Coverage under this benefit also includes 1 pair of eyeglasses when prescribed following cataract surgery with an intraocular lens implant. Eyeglasses must be obtained through Network Medical Group. Please refer to the Vision Supplement to the *Combined Evidence of Coverage and Disclosure* Form for pediatric vision benefits for Members.

    Special contact lenses for aniridia are limited to two Medically Nesserary contact lenses per eye in any 12-month period (including fitting and dispensing) to treat aniridia or missing iris, whether provided by the Health Plan during the current or a previous 12 month contract period.

    Special contact lenses to treat aphakia (absence of crystalline lens of the eye) are limited to six Medically Necessary contact lenses per eye per calendar year (including fitting and dispensing) whether provided by the Health Plan under the current calendar year.

    This benefit may be offered only for certain plan designs. If covered, please refer your *Schedule of Benefits*.

50. **Substance-Related and Addictive Disorder Services –** services for the prevention, diagnosis and treatment of mental health and substance use disorders. Mental health and substance use disorders are defined as a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

    - Outpatient Substance-Related and Addictive Disorder Services - Medically Necessary Substance-Related and Addictive Disorder services provided by a network practitioner at a network outpatient or Day Treatment Center and prior authorized, or at the office of a network practitioner including (but not limited to):
        - Diagnostic evaluations, assessment, and treatment planning.
        - Treatment and/or procedures.
        - Medication management and other associated treatments.
        - Individual, family, and group therapy.
        - Crisis intervention.
        - Medication-assisted treatment for Substance-Related and Addictive Disorders Services.

- Office-based medication-assisted opioid treatment, including methadone.
- Medication-assisted opioid treatment programs, including methadone, provided as part of or separate (stand-alone program) from a facility-based treatment program.
- Treatment programs at federally certified Methadone clinics.
- Prescription Drug Products.

- Outpatient Physician Care – Medically Necessary Substance-Related and Addictive Disorder Services provided by a network practitioner, and prior authorized by USBHPC, e.g. Intensive Outpatient Program Treatment, Partial Hospitalization/Day Treatment and outpatient treatment extending beyond 45 minutes. Such services must be provided at the office of the Network practitioner or at a network outpatient or Day Treatment Center.
- Methadone Maintenance Treatment - Medically Necessary methadone maintenance treatment is covered when prior authorized by USBHPC and provided at facilities licensed to provide such treatment.

Prescribed medications are covered as described in the *Outpatient Prescription Drug Benefit* supplement to this *Combined Evidence of Coverage and Disclosure Form*.

See your behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC as to how to obtain prior authorization and for any other further information.

See your *Schedule of Benefits* for any amounts you may have to pay.

For utilization review criteria, education programs and training materials relating to Mental Health Care and Substance-Related and Addictive Diroder Services contact us at www.myuhc.com or the telephone number on your ID card. Utilization review criteria, education programs and training materials relating to Mental Health Care and Substance-Related and Addictive Disorder Services will be provided at no cost to Members.

See Mental Health Services for mental health care services provided.

51. **Standard X-rays** –Standard X-rays are covered for the diagnosis of an illness or injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms), mammograms, obstetrical ultrasounds, and bone mineral density studies (including ultrasound and DEXA scans). See Specialized Scanning and Imaging Procedures in Outpatient Benefits for coverage and examples of specialized scanning and imaging procedures.
52. **Specialized Scanning and Imaging Procedures** – Specialized scanning and imaging procedures are covered for the diagnosis and ongoing medical management of an illness or injury. Specialized procedures are defined to include those which, unless specifically classified as Standard X-rays (see Standard X-rays, item # 46, in Outpatient Benefits*)*, are digitally processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of specialized scanning and imaging procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EMG, and nuclear scans, angiograms (includes heart catheterization), arthrograms, and myelograms, and non-obstetrical ultrasounds.
53. **Telehealth Services** – Benefits are available for applicable Covered Health Care Services received through Telehealth. Benefits are also provided for Remote Physiologic Monitoring. No in-person contact is required between a licensed health care provider and a Covered Person for Covered Health Care Services appropriately provided through Telehealth, subject to all terms and conditions of the Agreement.

    Prior to the delivery of Covered Health Care Services via Telehealth, the health care provider at the originating site shall verbally inform the Covered Person that Telehealth may be used and obtain verbal

consent from the Covered Person for this use. The verbal consent shall be documented in the Covered Person's medical record.

We shall not require the use of Telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

Telehealth does not replace the in-person diagnosis, consultation or treatment with your Primary Care Physician, treating Specialist or other health care Provider. Telehealth will be covered on the same basis and to the same extent as Covered Health Care Services delivered in-person. Telehealth services will also be subject to the same Deductible and/or Out-of-Pocket Limit as equivalent Covered Health Care Services delivered in person.

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

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Benefits are available for urgent, on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed. Virtual Care Services will be covered on the same basis and to the same extent as Covered Health Care Services delivered in-person. The Co-insurance or Co-payment for Virtual Care Services received through a Designated Virtual Network Provider will accrue to any applicable Deductible and/or Out-of-Pocket Limit.

Benefits do not include services that occur within medical facilities (CMS defined originating facilities).

You have the ability to receive services on an in-person basis or via Telehealth, if available, from your Primary Care Physician, treating Specialist, or from another Network individual health professional, clinic, or health facility. If you are currently receiving specialty Telehealth services for a mental or behavioral health condition, you may continue receiving that service with a Network individual health professional, clinic, or facility.

Prior to the delivery of Virtual Care Services, the Designated Virtual Network Provider shall verbally inform the Covered Person that Virtual Care Services may be used and obtain verbal consent from the Covered Person for this use. The verbal consent shall be documented in the Covered Person's medical record.

The Covered Person has the right to access his or her medical records, and the record of any Virtual Care.

Services provided by a Designated Virtual Network Provider shall be shared with the Covered Person's Primary Care Physician unless the Covered Person prohibits sharing his or her medical records.

III. Other Behavioral Health Care Services

1. **Ambulance** – Use of an ambulance (land or air) for Emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 Emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Health Care Services that require ambulance transport services.

   Use of an ambulance or a psychiatric transport service for a non-Emergency is covered only when specifically authorized by USBHPC and if:

   - USBHPC or a Network Practitioner determines the Member’s condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and
   - The use of other means of transportation would endanger the Member’s health.
   - These services are covered only when the vehicle transports the Member to or from covered Behavioral Health Care Services.

2. **Laboratory Services** – Diagnostic and therapeutic laboratory services are covered when ordered by a Network Practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Disorder and/or Substance-Related and Addictive Disorder.
3. **Inpatient Prescription Drugs** – Inpatient prescription drugs are covered only when prescribed by a USBHPC Network Practitioner for treatment of a Mental Disorder or Substance-Related and Addictive Disorder while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Substance-Related and Addictive Disorder a Residential Treatment Center.
4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a USBHPC Network Practitioner for treatment of a Mental Disorder.
5. **Psychological and Neuropsychological Testing** – Medically Necessary psychological testing is covered when authorized/ Prior Authorized by USBHPC and provided by a Network Practitioner who has the appropriate training and experience to administer such tests. neuropsychological testing does not require prior authorization unless required by the Health Plan.

IV. Exclusions and Limitations of Benefits

Unless described as a Covered Health Care Service in **Section 5. Your Medical Benefits** and the behavioral health supplement, the following services and benefits described below are excluded from coverage or limited under this Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*. (Note: Additional exclusions and limitations may be included with the explanation of your benefits in the additional materials.) For a list of other exclusions for behavioral health care services, please see your behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for USBHPC.

General Exclusions

1. Services that are provided without authorization from the Member's Network Medical Group or UnitedHealthcare (except for Emergency Health Care Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form*, and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, family practice Physician or surgeon designated by the Member's Network Medical Group as providing OB/GYN services) are not covered, except for Emergency Health Care Services and out-of-area Urgently Needed Services.
2. Services obtained from Out-of-Network Providers or Network Providers who are not affiliated with the Member’s Network Medical Group without authorization from UnitedHealthcare or the Network Medical Group are not covered, except for Emergency Health Care Services and out-of-area Urgently Needed Services.
3. Services provided prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. UnitedHealthcare does not cover the cost of services provided in preparation for a non-Covered Health Care Service where such services would not otherwise be Medically Necessary. Additionally, UnitedHealthcare does not cover the cost of routine follow-up care for non-Covered Health Care Services (as recognized by the organized medical community in the State of California). UnitedHealthcare will cover Medically Necessary services directly related to non-Covered Health Care Services when complications exceed routine follow-up care.
5. Services performed by immediate relatives or members of your household are not covered.
6. Services obtained outside the Service Area are not covered except for Emergency Health Care Services or Urgently Needed Services.

Other Exclusions and Limitations

1. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.

2. **Ambulance** – Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation would be more appropriate. Wheelchair transportation services (e.g., a private vehicle or taxi fare are also not covered).

   Please refer to "Ambulance" in the Outpatient Benefits section and Organ Transplants in the Other Exclusions and Limitations section.

3. **Artificial Hearts** – Artificial hearts are considered Experimental and are, therefore, not covered.

   A Member may be entitled to an expedited external, independent review of UnitedHealthcare's coverage determination regarding Experimental or Investigational therapies as described in **Section 8**.

4. **Bariatric Surgery** – Bariatric surgery will only be covered when Medically Necessary for the treatment of Morbid Obesity. We will use evidence-based criteria to determine coverage of bariatric surgery, such as the most recent National Institutes of Health (NIH) guidelines, in determining the Medical Necessity of requests for surgical treatment for morbid obesity. UnitedHealthcare evaluation encourages a multidisciplinary team approach that includes medical, surgical, psychological, and nutritional expertise for those who are seeking surgical weight-loss. After surgery, the Member takes part in a multidisciplinary program of diet, exercise, and behavior modification.

   Surgical treatments for morbid obesity and services related to this surgery are subject to prior approval by UnitedHealthcare's Medical Director or designee. Please also see Weight Alteration Program (Inpatient or Outpatient).

5. **Behavior Modification** – Behavior modification is not covered. Behavior modification is used in behavioral programs to designate methods for conditioning behavior by joining a behavior with a reinforcement to reward the person if they implement a desired behavior or if they stop undesired behavior. Behavior modification can also involve incurring an unpleasant consequence for undesired behavior. Behavior modification may involve setting goals for desired behavior; goals are specific, measurable, attainable, and age-and developmental stage-appropriate. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Network Qualified Autism Service Provider, and are provided by a Network Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply or exclude medically necessary behavior health therapy services for treatment of Autism Spectrum Disorder.

6. **Bloodless Surgery-** Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin for members are covered when Medically Necessary and prior authorization is obtained.

7. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is not covered except when either of the following applies:

   a. For Members with craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid, or

   b. For Members with hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

   Repairs and/or replacement for the implanted components of a bone-anchored hearing aid for a Member who meets the above coverage criteria are not covered, other than for malfunctions. Replacement of external hearing aid components for bone-anchored hearing aids is covered under the DME benefit. External components for bone-anchored hearing aids are either body-worn or worn behind the ear. Examples of external components include an external abutment and a sound processor. Replacement of external hearing aid components is only covered due to malfunction and when the condition of the device or part requires repairs that exceed the cost of replacement. Deluxe model and upgrades that are not Medically Necessary are not covered.

8. **Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form* under the caption, "Independent Medical Review Procedures." The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors take place through a registry are covered when the Member is the intended recipient. Unrelated donor searches must be performed at a UnitedHealthcare-approved transplant center. (See Designated Facility in **Definitions**.)
9. **Breast Pumps** – Covered Health Care Services are limited to one breast pump in conjunction with childbirth. The breast pump must be obtained from a Network Provider as determined by the Member's Network Medical Group or by UnitedHealthcare. If more than one breast pump can meet the Member's needs, Covered Health Care Services are available only for the most cost effective pump that meets the Member's needs. The Member's Network Medical Group or UnitedHealthcare will determine the following:
    - Which pump is the most cost-effective.
    - Timing of a purchase.
10. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered. For a detailed listing of covered DME and prosthetic and corrective appliances, please call our Customer Service department at 1-800-624-8822.
11. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine are not covered unless purchased by your Group as a supplemental benefit. Religious nonmedical health care is not covered. (See the definition for "Complementary and Alternative Medicine.")
12. **Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered.
13. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice facility incident to a Member's terminal illness as described in the explanation of Hospice services in the Medical Benefits section of this *Combined Evidence of Coverage and Disclosure Form*. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. This exclusion does not apply to authorized Medically Necessary covered services provided to a Member residing in a Custodial Care facility .
14. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the outpatient benefit captioned, Oral Surgery and Dental Services, dental care, dental appliances and orthodontics are not covered. Dental care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for dental care may be available if purchased by the Subscriber's employer as a separate benefit. If your Health Plan includes a dental care separate benefit, a brochure describing it will be enclosed with these materials.) Please refer to the Dental Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric dental benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.
15. **Dental Treatment Anesthesia** – Dental treatment anesthesia provided or administered in a dentist's office is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures

directly supporting the teeth, are not covered except for services covered by UnitedHealthcare under the outpatient benefit, Oral Surgery and Dental Services. Please refer to the Dental Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric dental benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.

16. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Network Medical Group. The fact that the Member is outside the geographic area served by the Network Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.
17. **Disabilities Connected to Military Services** – Treatment in a government Facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency and to which Member has reasonable access is not covered.
18. **Drugs and Prescription Medication (Outpatient)** – Infusion drugs, infusion therapy and prescribed contraceptive drugs required by Federal law are not considered outpatient drugs for the purposes of this exclusion.Pen devices for the delivery of medication, other than insulin or as required by law, are not covered. Refer to the *Outpatient Prescription Benefit* supplement and to the Pharmacy *Schedule of Benefits* for benefit coverage.
19. **Durable Medical Equipment (DME)** – Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of a significant change in the Member's physical condition. Replacement of lost or stolen DME is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to DME for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to fit the Member's physical condition. For a detailed listing of covered DME, please call our UnitedHealthcare Customer Service department at 1-800-624-8822.

    Please refer to "Bone-Anchored Hearing Aid" in the "Outpatient Benefits" section and in the "Other Exclusions and Limitations" section for a description of coverage for external hearing aid components subject to the DME benefit and limitations.
20. **Educational Services for Developmental Delays and Learning Disabilities** – Educational services for Developmental Delays and Learning Disabilities are not Covered Health Care Services. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade are not covered. The Plan does not cover tutoring, special education/instruction required to help a child to make academic progress: academic coaching, teaching Members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

    UnitedHealthcare refers to *American Academy of Pediatrics, Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services.

    We do not cover any of the following:

    - Items and services to increase academic knowledge or skills;
    - Special education (teaching to meet the educational needs of a person with an intellectual disability, Learning Disability, or Developmental delay). A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development. This exclusion does not apply to Covered Health Care Services when they are authorized, part of a Medically Necessary treatment plan, provided under the supervision of a licensed or certified health

- care professional and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law;
- Teaching and support services to increase academic performance;
- Academic coaching or tutoring for skills such as grammar, math, and time management;
- Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Network Provider acting within the scope of his or her license under California law that is intended to address speech impairments;
- Teaching how to read, whether or not the Member has dyslexia;
- Educational testing;

This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.

21. **Elective Enhancements** – Procedures, technologies, services, drugs, devices, items, and supplies for elective, non-Medically Necessary improvements, alterations, enhancements or augmentation of appearance, skills, performance capability, physical or mental attributes, or competencies are not covered. This exclusion includes, but is not limited to, elective improvements, alterations, enhancements, augmentation, or genetic manipulation related to hair growth, aging, athletic performance, intelligence, height, weight, or cosmetic appearance. This exclsuions does not apply when Medically Necessary for the treatment of Mental Health and Sustance Use Disorders.
22. **Enteral Feeding** – Enteral Feedings (food, and formula) including Phenylketonuria (PKU) and the accessories and supplies are not covered except as shown under Enteral and Parenteral Nutrition. Food products naturally low in protein are not covered. Pumps and tubing are covered under DME in Outpatient Benefits.
23. **Exercise Equipment and Services** – Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.
24. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental or Investigational Services and all services related to Experimental, or Investigational Services are excluded unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*.

    The fact that an Experimental or Investigational 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 in the treatment of that particular condition.

    Exceptions:

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

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

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

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

A Member with a life-threatening or seriously debilitating condition may be entitled to an expedited external, independent review of UnitedHealthcare's coverage determination regarding Experimental or Investigational therapies as described in **Section 8. Overseeing Your Health Care**, "Experimental or Investigational Treatment Decisions."

25. **Eyewear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for the treatment of keratoconus aphakia and aniridia, as a corneal bandage, and one pair after each cataract extraction). Surgical and laser procedures to correct or improve refractive error are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.) Routine screenings for glaucoma are limited to Members who meet the medical criteria. Please refer to the Vision Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric vision benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.
26. **Family Planning** – Family planning benefits, other than those specifically listed in the Family Planning outpatient benefit and in the *Schedule of Benefits* that accompanies this document, are not covered.
27. **Follow-up Care: Emergency Health Care Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Health Care Services or Urgently Needed Services, including, but not limited to, treatments, procedures, x-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Care, are not covered without the Network Medical Group's or UnitedHealthcare's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Network Medical Group will not entitle the Member to coverage.
28. **Foot Care** – Except as Medically Necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.
29. **Foot Orthotics/Footwear** Benefits are limited to custom orthotic devices required to support or correct a defective body part, and for those who suffer from foot disfigurement caused by, but not limited to, cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement caused by accident or

developmental disability or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace as described under Footwear in the Outpatient Benefits section. Dress shoes, casual shoes (e.g., tennis shoes), shoe inserts, foot pad, foot orthotics that are soft, molded or made from cork or leather, socks or any supplies that are not custom-made or have an equivalent that can be purchased without a prescription are not covered. Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Network Medical Group or UnitedHealthcare.

30. **Genetic Testing, Treatment or Counseling** – Non-Medically Necessary screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to begin medical interventions/treatment while a newborn, a child or adolescent. Members who have no clinical evidence or family history of a genetic abnormality.

    Refer to Preventive Care Services and Maternity Care, Tests, Procedures, and Genetic Testing" in the "Outpatient Benefits section for coverage of amniocentesis and chorionic villus sampling.

31. **Government Services and Treatment** – Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law or as noted below:

    - **Services While Confined or Incarcerated** – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined according to federal, state or local law are not covered. However, UnitedHealthcare will reimburse Members their out-of-pocket expenses for services received while confined/incarcerated, or, if a juvenile, while detained in any Facility, if the services were provided or authorized by your PCP or Network Medical Group in agreement with the terms of this Health Plan or were Emergency Health Care Services or Urgently Needed Services. This exclusion does not restrict UnitedHealthcare's liability with respect to expenses for Covered Health Care Services solely because the expenses were incurred in a state or county hospital; however, UnitedHealthcare's liability with respect to expenses for Covered Health Care Services provided in a state hospital is limited to the rate UnitedHealthcare would pay for those Covered Health Care Services if provided by a Network Hospital.

32. **Hearing Aids and Hearing Devices** – Hearing aids, including repairs and replacements, are covered up to the limits described in the *Schedule of Benefits*. Replacement of a hearing aid is only covered when the condition of the device or part requires repairs that exceed the cost of a replacement hearing aid. Hearing aids or hearing devices are limited to one hearing aid (including repair or replacement) per hearing impaired ear every three years.

33. **Hospice Services** – Hospice services are not covered for:

    a. Members who do not meet the definition of terminally ill. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one year if the disease follows its natural course.

    b. Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a non-certified Hospice program).

    Note: Hospice services provided by an Out-of-Network Hospice agency are not covered except in certain circumstances in counties in California in which there are no Network Hospice agencies and only when prior authorized and arranged by UnitedHealthcare or the Member's Network Medical Group.

34. **Human Growth Hormone** – Human growth hormone injections for the treatment of idiopathic short stature are covered only when determined Medically Necessary by a UnitedHealthcare Medical Director or designee.

35. **Immunizations** – Immunizations and vaccines solely for international travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered, except as otherwise recommended by the national advisory organizations referenced in the section, “Outpatient Benefits”, “Preventive Care Services.” Routine boosters and immunizations must be obtained through the Member's Network Medical Group.

36. **Implants** – The following implants and services are not covered:

    - Surgical implantation or removal of breast implants for nonmedical reasons.
    - Replacement of breast implants when the first surgery was done for nonmedical reasons, such as for cosmetic breast augmentation mammoplasty or after cosmetic breast reduction mammoplasty.

    UnitedHealthcare will cover Medically Necessary services directly related to non-Covered Health Care Services when complications exceed routine follow-up care.

37. **Infertility Reversal** – Reversals of sterilization procedures are not covered.

38. **Infertility Services** – Infertility services are not covered unless purchased by the Subscriber’s Employer Group. Please refer to your *Schedule of Benefits*. The following services are excluded under the UnitedHealthcare Health Plan: ovum transplants, ovum or ovum bank charges and sperm or sperm bank charges, except Medically Necessary iatrogenic infertility preservation, and the Medical or Hospital Services incurred by surrogate mothers who are not UnitedHealthcare Members are not covered. Medical and Hospital Infertility Services for a Member whose fertility is impaired due to an elective sterilization, including surgery, medications and supplies, are not covered.

39. **Institutional Services and Supplies** – Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies provided by a facility that is mainly a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled nursing services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections titled, “Inpatient Benefits” and “Outpatient Benefits.”) Members residing in these facilities are eligible for Covered Health Care Services that are determined to be Medically Necessary by Member’s Network Medical Group or UnitedHealthcare, and are provided by Member’s PCP or authorized by Member’s Network Medical Group or UnitedHealthcare.

40. **Maternity Care, Tests, and Procedures** – Elective home deliveries are not covered. Educational courses or child care and/or prepared childbirth classes are not covered.

41. **Mental Health and Nervous Disorders** – Mental health services are not covered except for diagnosis and treatment of Mental Disorders as described in **Section 5. Your Medical Benefits** and as defined in **Section 10. Definitions**. Educational services for Developmental Delays and Learning Disabilities are not health care services and are not covered. (For information regarding excluded Educational Services, please refer to Educational Services.)

42. **Non-Physician Health Care Practitioners** – This Health Plan may not cover services of all Non-Physician Health Care Practitioners. Network Qualified Autism Service Providers, Network Qualified Autism Service Professionals, Network Qualified Autism Service Paraprofessionals are covered when criteria are met as authorized by your Network Medical Group or UnitedHealthcare. Treatment by other Non-Physician Health Care Practitioners other than as shown in **Section 5: Your Medical Benefits**, Outpatient Benefits may be available if purchased as a supplemental benefit. (For coverage of Mental Disorder, refer to Inpatient and Outpatient Benefits, Mental Health Services.) This exclsuions does not apply when Medically Necessary for the treatment of Mental Health and Sustance Use Disorders.

43. **Nurse-Midwife Services** – Licensed/Certified nurse-midwife services are covered only when available within the Member’s Network Medical Group. Elective home deliveries are not covered.

44. **Nursing Services, Private Duty** – Private-Duty Nursing Services are not covered. Private-Duty Nursing Services include nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

45. **Nutritional Supplements or Formulas** – Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the outpatient description of Enteral and Parenteral Nutrition. This exclsuions does not apply when Medically Necessary for the treatment of Mental Health and Sustance Use Disorders.

46. **Off-Label Drug Use** – Off-label drug use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved by the FDA, including off-label self-injectable drugs, is not covered except as follows: If the self-injectable drug is prescribed for off-label use, the drug and its administration is covered only when the following criteria are met:

    - The drug is approved by the FDA;
    - The drug is prescribed by a Network Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:

        a. The American Hospital Formulary Service's Drug Information,

        b. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

            (i) The Elsevier Gold Standard's Clinical Pharmacology;

            (ii) The National Comprehensive Cancer Network Drug and Biologics Compendium;

            (iii) The Thomson Micromedex DRUGDEX, or

        c. two (2) articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

    Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary, Co-payment or Deductible, and or the use of a technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different than the use for which the drug has been approved for marketing by the FDA. Benefits will also include Medically Necessary Covered Health Care Services related to the administration of a drug subject to the conditions of this *Combined Evidence of Coverage and Disclosure Form* and the supplements of this document.

47. **Oral Surgery and Dental Services** – Dental services, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered except for Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Refer to Reconstructive Surgery procedure. Please refer to the Dental Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric dental benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.

48. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered. (Please see Dental Care, Dental Appliances and Orthodontics and Dental Treatment Anesthesia.) Please refer to the Dental Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric

dental benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.

49. **Organ Donor Services** – Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors take place through a registry are covered when the Member is the intended recipient. Donor searches are only covered when performed by a Provider included in the Designated Facility.
50. **Organ Transplants** – All organ transplants must be Prior Authorized by UnitedHealthcare and performed in a Designated Facility.
    - Transportation is limited to the transportation of the Member and one escort to a Designated Facility greater than 60 miles from the Member's Primary Residence as Prior Authorized by UnitedHealthcare. Transportation and other non-clinical expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for Designated Facility.)
    - Food and housing are not covered unless the Designated Facility is located more than 60 miles from the Member's Primary Residence, in which case food and housing are limited to $125 a day to cover both the Member and escort, if any (excludes alcohol and tobacco) as Prior Authorized by UnitedHealthcare. Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
    - Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency (the agency that obtains the organ) is the same for both facilities. Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, UnitedHealthcare will only cover the costs related to the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the facility where the transplant is performed. The Member is responsible for any duplicated diagnostic costs for a transplant review incurred at the second facility. (See the definition for Regional Organ Procurement Agency under Designated Facility.)
    - Artificial heart implantation and non-human organ transplantation are considered Experimental and are therefore excluded. Please refer to the exclusion titled, Experimental and/or Investigational Procedures, Items and Treatment and to the Independent Medical Review process outlined in **Section 8**.
51. **Pain Management** – Pain management services are covered for the treatment of long term and acute pain only when they are received from a Network Provider and authorized by UnitedHealthcare or its designee.
52. **Physical or Psychological Exams** – Physical or psychological exams for court hearings, travel, premarital, pre-adoption, employment or other non-health reasons are not covered. Court-ordered or other statutorily allowed psychological review, testing, and treatment are not covered. (For a description of mental health care services, please refer to **Section 5 Your Medical Benefits** and to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC.)
53. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during inpatient hospitalization are not covered.
54. **Prosthetics and Corrective Appliances/ Orthotics** – Replacement of prosthetics or corrective appliances/ orthotics is covered when determined Medically Necessary by the Member's Network Medical Group or UnitedHealthcare. Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics are not covered. Deluxe upgrades that are not Medically Necessary are not covered. For a

detailed listing of covered DME and prosthetics and corrective appliances, please call our Customer Service department at 1-800-624-8822.

55. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by a UnitedHealthcare Medical Director or designee.
56. **Reconstructive Surgery** – Reconstructive surgeries are not covered under the following circumstances:
    - When there is another more appropriate surgical procedure that has been offered to the Member; or
    - When only a minimal improvement in the Member's appearance is expected to be achieved.

    Prior Authorizations for proposed reconstructive surgeries will be reviewed by Physicians specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested. This exclsuions does not apply when Medically Necessary for the treatment of Mental Health and Sustance Use Disorders.
57. **Rehabilitation and Habilitative Services and Therapy** – Rehabilitation and Habilitative Services and therapy will be provided only as Medically Necessary and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law.
    - Speech, occupational or physical therapy are not covered when medical or mental health documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals.
    - Cognitive Habilitation and Rehabilitation Therapy is limited to neuropsychological testing by a Provider acting within the scope of his or her license or as authorized under California law and the Medically Necessary treatment of functional deficits due to a traumatic brain injury or cerebral vascular insult or when provided as part of an authorized autism behavioral health treatment plan. This benefit is limited to outpatient habilitation and rehabilitation limitation, if any and inpatient only when a Member also meets criteria for inpatient medical rehabilitation and Habilitative Services.
    - Developmental Testing beyond the first diagnosis is limited to Medically Necessary testing for medical conditions, Autism Spectrum Disorder.
    - Exercise programs are only covered when they are part of an authorized treatment plan and require the supervision of a licensed physical therapist and are provided by an authorized provider acting within his or her license or as authorized under California law.
    - Activities that are solely recreational, social or for general fitness, such as gyms and dancing classes, are not covered.
    - Aquatic/pool therapy is not covered unless it is part of an authorized treatment plan and is provided by a licensed physical therapist who is a Network Provider acting within the scope of his or her license or as authorized under California law.
    - Massage therapy is not covered except if it is part of a physical therapy treatment plan and covered under Inpatient Hospital, Outpatient Services, Home Health Care, Hospice Services, or Skilled Nursing Care in this Evidence of Coverage.

    The following Habilitation and Rehabilitation Services, special reviews and therapies are not covered:
    - Cognitive Behavioral Therapy, unless Medically Necessary and provided by a Network Provider acting within the scope of his or her license or as authorized under California law.
    - Hypnotherapy
    - Psychological and Neuropsychological Testing unless Medically Necessary to diagnose and treat an illness, including Mental Disorders or injury.

Vocational Habilitation and Rehabilitation.

This exclsuions does not apply when Medically Necessary for the treatment of Mental Health and Sustance Use Disorders.

58. **Reproduction Services -** including, but not limited to: sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of the fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus.
59. **Respite Care** – Respite care is not covered, unless part of an authorized Hospice plan and is needed to relieve the primary caregiver in a Member's residence. Respite care is covered only on an occasional basis, not to exceed five consecutive days at a time.
60. **Routine Laboratory Testing Out-of-Area** – Routine laboratory tests are not a covered benefit while the Member is outside of the geographic area served by the Member's Network Medical Group. Although it may be Medically Necessary, out-of-area routine laboratory testing is not considered an Urgently Needed Service because it is not unforeseen and is not considered an Emergency Health Care Service.
61. **Sexual Dysfunction or Inadequacy Medications** – Sexual dysfunction or inadequacy medications/drugs, procedures, services, and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels are not covered. This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.
62. **Sperm preservation in advance of hormone treatment or gender surgery.**
63. **Surgical treatment not prior authorized by UnitedHealthcare or designee.**
64. **Surrogacy** – Infertility and maternity services for non-Members are not covered.
65. **Third-Party Liability** – Expenses incurred due to liable third parties are not covered, as described in the section, UnitedHealthcare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses.
66. **Transportation** – Transportation is not a covered benefit except for ambulance transportation as defined in this Combined Evidence of Coverage and Disclosure Form.

    Also see Organ Transplants listed in Other Exclusions and Limitations. Additionally, you can refer to the Benefit Interpretation Policy Manual as to transportation relating to Gender Dysphoria.
67. **Treatment received outside the United States –** Surgery or non-surgical treatment for gender dysphoria performed outside of the United States is not covered.
68. **Vision Care** – See Eyewear and Corrective Refractive Procedures listed in Other Exclusions and Limitations. Please refer to the Vision Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric vision benefits for Members who are covered until at least the end of the month in which Member turns 19 years of age.
69. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
70. **Visual Aids** – Visual aids are not covered, except as shown under the outpatient benefit for Diabetic Self-Management Items. Electronic and nonelectronic magnification devices are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit.) Please refer to the Vision Supplement to the *Combined Evidence of Coverage and Disclosure Form* for pediatric vision benefits for Members who are covered until at least the end of the month in which Member turns19 years of age.

71. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered except as noted in this paragraph. These programs include, but are not limited to, dietary reviews, counseling, exercise, behavioral modification, food and food supplements, vitamins and other nutritional supplements. Also excluded are nonauthorized weight loss program laboratory tests related to monitoring weight loss or weight gain, except as described under inpatient benefits Morbid Obesity (Surgical Treatment). For further information on benefits, please refer to **Section 5: Your Medical Benefits**. This exclsuions does not apply when Medically Necessary for the treatment of Mental Health and Sustance Use Disorders.

    For all adults, the United States Preventive Services Task Force recommends screening for obesity. Providers should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. Services performed in a Network Physician's office are described under Preventive Care Services in **Section 5: Your Medical Benefits**.

Are Incentives Available to You?

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

SECTION 6. PAYMENT RESPONSIBILITY

- **What are Premiums and Co-payments**
- **What to Do if You Get a Bill**
- **Coordinating Benefits**
- **Medicare Eligibility**
- **Workers' Compensation Eligibility**
- **Other Benefit Coordination Issues**

This section explains these and other health care expenses. It also explains your responsibilities when you are eligible for Medicare or workers' compensation coverage and when UnitedHealthcare needs to coordinate your benefits with another plan.

What are Premiums?

Premiums are fees an Employer Group pays to cover the basic costs of your health care package. An Employer Group usually pays these Premiums on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary.

If you are the Subscriber, you should already know if you are contributing to your Premium payment; if you are not sure, contact your Employer Group's health benefits representative. He or she will know if you are contributing to your Premium, as well as the amount, method and frequency of this contribution.

What are Co-payments?

You may be responsible for paying a charge when you receive a Covered Health Care Service. This charge is called a Co-payment and is outlined in your *Schedule of Benefits*. If you review your *Schedule of Benefits*, you will see that the amount of the Co-payment depends on the service, as well as the Provider from whom you choose to receive your care.

For HSAs only: If you intend to use this Health Plan with a Health Savings Account (HSA), you must open an HSA with a financial institution qualified under applicable federal law and Internal Revenue Service Rules. Please seek professional guidance from your tax or financial advisor.

What is a Calendar Year Deductible?

The Calendar Year Deductible is the amount incurred for a Covered Health Care Service that you are responsible for paying each Calendar Year before benefits are payable under the *Combined Evidence of Coverage and Disclosure Form*. The amounts applied towards the Calendar Year Deductible are based upon the Health Plan's contracted rate. The Deductible is waived for certain Covered Health Care Services. Please refer to the *Schedule of Benefits* for detailed information on the Deductible amount and Covered Health Care Services subject to the Deductible. If your coverage includes a Deductible, we will not cover certain services until you meet the Deductible each Calendar Year. The Calendar Year Deductible is in addition to any Co-payment responsibility. The Calendar Year Deductible applies to the Annual Out of Pocket Limit. If you feel you have surpassed your annual Deductible amount, you may submit all of your health care receipts for Covered Health Care Services that are subject to the Deductible to the address provided below along with a letter of explanation.

Individual/Family Deductible

When the amount incurred for Covered Health Care Services for all Family Members accrue to the amount indicated on the *Schedule of Benefits*, no additional Calendar Year Deductible will apply to the other Family Members for the rest of that Calendar Year.

All Health Plans have an Embedded Individual/Family Deductible.: The individual deductible is embedded in the family deductible. When an individual Member of a family unit satisfies the Individual Deductible for the

Calendar Year, no further Deductible will be required for that individual Member for the remainder of the Calendar Year.

The remaining family Members will continue to pay full Member charges for services that are subject to the deductible until the Member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

Annual Co-payment Limit

For certain Covered Health Care Services, there is a limit placed on the total amount you pay for Co-payments during a calendar year. This limit is called your Annual Co-payment Limit, and when you reach it, for the remainder of the calendar year, you will not pay any additional Co-payments for these Covered Health Care Services. Co-payments paid for certain Covered Health Care Services are not applicable to a Member's Annual Co-payment Limit; these services are shown in the *Schedule of Benefits*.

When an individual Member meets the Annual Co-payment Limit, no further Co-payments are required for the year for that individual.

Note: The calculation of your Annual Co-payment Limit includes UnitedHealthcare benefits, including behavioral health, pediatric dental, pediatric vision, acupuncture and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision, chiropractic and infertility, if purchased by your employer, benefit plans that may be offered by your Employer Group.

What If You Get a Bill?

If you are billed for a Covered Health Care Service provided or authorized by your PCP or Network Medical Group or if you receive a bill for Emergency or Urgently Needed Services, you should do the following:

1. Call the Provider, then let them know you have received a bill in error and you will be forwarding the bill to UnitedHealthcare.
2. Give the Provider your UnitedHealthcare Health Plan information, including your name and UnitedHealthcare Member number.
3. Forward the bill to:

   UnitedHealthcare of California
   Claims Department
   P.O. Box 30968
   Salt Lake City, UT 84130-0968

Include your name, your UnitedHealthcare Health Plan ID number and a brief note that indicates you believe the bill is for a Covered Health Care Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required. If you need additional help, call our Customer Service department.

Please Note: Your Provider will bill you for services that are not covered by UnitedHealthcare or have not been properly authorized. You may also receive a bill if you have exceeded UnitedHealthcare's coverage limit for a benefit.

Deductible and Out-of-Pocket-Limit Accrual Balances

Up-to-date Deductible and Out-of-Pocket Limit accrual balances will be provided to you as you use Benefits and will appear on your Explanation of Benefits and/or Health Statement or at any time by visiting www.myuhc.com, or by contacting us at the telephone number on your ID card.

You may choose to receive this information electronically by registering for paperless delivery at www.myuhc.com, or by contacting us at the telephone number on your ID card.

What is a *Schedule of Benefits*?

Your *Schedule of Benefits* is printed separately from this document and lists the Covered Health Care Services unique to your Health Plan. It also includes your Co-payments/Deductibles, as well as the Annual Co-payment Limit and other important information. If you need help understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service department.

Bills From Out-of-Network Providers

If you receive a bill for a Covered Health Care Service from a Physician who is not one of our Network Providers, and the service was Prior Authorized and you have not exceeded any applicable benefit limits, UnitedHealthcare will pay for the service, less the applicable Co-payment/Deductible. (Prior Authorization is not required for Emergency Health Care Services and Urgently Needed Services. See **Section 3. Emergency Health Care and Urgently Needed Services**.) Out-of-Network Providers may not send you a bill for Emergency Health Care Services. You are only required to pay the Co-payment/Deductible amount shown in your *Schedule of Benefits*. You may also submit a bill to us if an Out-of-Network Provider has refused payment directly from UnitedHealthcare.

If you receive Covered Health Care Services in a Network contracting health care facility but from an Out-of-Network individual health professional, you are only required to pay the Co-payment/Deductible amount specified in your Schedule of Benefits. A Network "contracting health facility" includes, but not limited to, a licensed hospital; ambulatory surgery center or other outpatient setting, lab, radiology or imaging center. You should not be billed more than the amounts shown on your Schedule of Benefits.

You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

UnitedHealthcare of California
Claims Department
P.O. Box 30968
Salt Lake City, UT 84130-0968

Include your name, UnitedHealthcare Health Plan ID number and a brief note that indicates your belief that you have been billed for a Covered Health Care Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required.

UnitedHealthcare will make a determination within 30 working days from the date UnitedHealthcare receives a claim containing all information reasonably needed to decide the claim. UnitedHealthcare will not pay any claim that is filed more than 180 calendar days from the date the services or supplies were provided. UnitedHealthcare also will not pay for excluded services or supplies unless authorized by your PCP, your Network Medical Group or directly by UnitedHealthcare.

Any payment assumes you have not exceeded your benefit limits. If you have reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How Do You Avoid Unnecessary Bills?

Always obtain your care under our direction, your Network Medical Group, or your PCP. By doing this, you only will be responsible for paying any related Co-payments and for charges in excess of your benefit limitations. Except for Emergency Health Care Services or Urgently Needed Services, if you receive services not authorized by UnitedHealthcare or your Network Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by your Health Plan. (Services not covered by your Health Plan are included in **Section 5. Your Medical Benefits**.)

Your Billing Protection

All our Members have rights that protect them from being charged for Covered Health Care Services in the event a Network Medical Group does not pay a Provider, a Provider becomes insolvent, or a Provider breaches its contract with UnitedHealthcare. In none of these instances may the Network Provider send you a

bill, charge you, or have any other recourse against you for a Covered Health Care Service. However, this provision does not prohibit the collection of Co-payment/Deductible amounts as outlined in the *Schedule of Benefits*.)

In the event of a Provider's insolvency, UnitedHealthcare will continue to arrange for your benefits. If for any reason UnitedHealthcare is unable to pay for a Covered Health Care Service on your behalf (for instance, in the unlikely event of UnitedHealthcare's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your UnitedHealthcare Network Provider. You may, however, be responsible for any properly authorized Covered Health Care Services from an Out-of-Network Provider or Emergency Health Care Services or Urgently Needed Services from an Out-of-Network Provider.

Note: If you receive a bill because an Out-of-Network Provider refused to accept payment from UnitedHealthcare, you may not be billed for authorized services for anything except your Co-payments/Deductibles. Please call Customer Services for assistance or submit a claim for reimbursement. See above: Bills From Out-of-Network Providers.

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. Plan is defined below. COB is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group health plans that provide coverage to an individual will pay no more than 100 percent of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group Health Plan provides benefits in the form of services rather than cash payments.

UnitedHealthcare's COB activities will not interfere with your medical care.

The order of benefit determination rules below determine which Health Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense. Allowable Expense is defined below.

Definitions

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

   1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a Plan as defined here; however, UnitedHealthcare does coordinate benefits with Medicare. Please refer to **Section 6**, Important Rules for Medicare and Medicare-Eligible Members.

   2. **Plan** does not include: amounts of hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, a state plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under (1) above is a separate Plan. However, if the same carrier provides coverage to Members of a group under more than one group contract each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan and there is no

COB among those separate contracts. However, if a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when compared to another Plan covering the person.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense** means a health care service or expense, including Deductibles and Co-payments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are **not** Allowable Expenses:

   1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is Medically Necessary) is not an Allowable Expense.
   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.
   5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.

F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group Health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among UnitedHealthcare and other applicable group Health Plans be establishing which plan is primary, secondary and so on:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to

supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-Network benefits.

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

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent, for example as an Eligible Employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

   a. **Birthday Rule.** The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the "Eligibility" section of this *Combined Evidence of Coverage and Disclosure Form*. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.

   c. If the parents are not married and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

      - The Plan of the Custodial Parent;
      - The Plan of the legal spouse or Domestic Partner of the Custodial Parent;
      - The Plan of the non-Custodial Parent; and then
      - The Plan of the legal spouse of the non-Custodial Parent.

3. **Active or Inactive Eligible Employee.** The Plan that covers a person as an Eligible Employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid-off or retired Eligible Employee (or his or her Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working legal spouse or Domestic Partner will be determined under the rule labeled D(1).

4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA (Cal-COBRA)) also is covered under another Plan, the Plan covering the person as an Eligible Employee, Member,

Subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order of payment, the Plan that covered the person as an Eligible Employee, Member, Subscriber or retiree for the longer period is primary.

Effect on the Benefits of This Plan

- When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.
- If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

UnitedHealthcare may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this Plan must give UnitedHealthcare any facts it needs to apply those rules and determine benefits payable. UnitedHealthcare may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including, but not limited to, diagnoses payment of health care services provided, billing, claims management or other administrative functions of UnitedHealthcare, without obtaining the Member's consent, in agreement with state and federal law.

UnitedHealthcare's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, UnitedHealthcare may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. UnitedHealthcare will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made includes providing benefits in the form of services, in which case, payment made means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by UnitedHealthcare is more than it should have paid under this COB provision, UnitedHealthcare may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

Important Rules for Medicare and Medicare-Eligible Members

You must let UnitedHealthcare know if you are enrolled, or eligible to enroll, in Medicare (Part A and/or Part B coverage). UnitedHealthcare is typically primary (that is, UnitedHealthcare's benefits are determined before those of Medicare) to Medicare for some initial period of time, as determined by the Medicare regulations. After the initial period of time, UnitedHealthcare will be secondary to Medicare (that is, the benefits under this Health Plan will be reduced to the extent they duplicate any benefits provided or available under Medicare, if the Member is enrolled or eligible to enroll in Medicare.)

You can become entitled to Medicare three different ways: because of age, disability, or end stage renal disease (ESRD).

If you have group health insurance through a plan that either you or your legal spouse received through and Employer Group that you are actively working at, that insurance is primary over Medicare. However, there are three exceptions to this rule:

1. Employer Group with less than 20 Eligible Employees;
2. Disabled individual; or
3. Members who are entitled to Medicare due to End Stage Renal Disease (ESRD).

Medicare is primary for Employer Groups that have fewer than 20 full-and part-time Eligible Employees. Also, Medicare is primary for disabled Members if their Employer Group has fewer than 100 Eligible Employees.

If you have questions about the coordination of Medicare benefits, contact your Employer Group or our Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers' Compensation

UnitedHealthcare will not provide or arrange for benefits, services or supplies required due to a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers' Compensation Act, occupational disease laws, employer's liability or federal, state or municipal law, To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers' Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers' Compensation Appeals Board.

If for any reason UnitedHealthcare provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse UnitedHealthcare for the benefits, services or supplies provided or arranged for, at Prevailing Rates, after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected due to a workers' compensation action in trust for UnitedHealthcare. This award will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits provided to him or her or on his or her behalf by UnitedHealthcare for each incident. If the Member receives a settlement from workers' compensation coverage that includes payment of future medical costs, the Member must reimburse UnitedHealthcare for any future medical expenses related to this judgment if UnitedHealthcare covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, UnitedHealthcare will provide or arrange for benefits until such dispute is resolved, if the Member signs an agreement to reimburse UnitedHealthcare for 100 percent of the benefits provided.

UnitedHealthcare will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions of law under the Workers' Compensation Act. Benefits will not be denied to a Member whose employer has not complied with the laws and regulations governing workers' compensation insurance, provided that such Member has sought and received Medically Necessary Covered Health Care Services under this Health Plan.

Third-Party Liability – Expenses Incurred Due to Liable Third Parties Are Not Covered

Health care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, UnitedHealthcare will pay for the arrangement or provision of health care services for a Member that would have been Covered Health Care Services except that they were required due to a liable third party, in exchange for the agreement as expressly described in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned,

UnitedHealthcare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses.

UnitedHealthcare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses

Expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, UnitedHealthcare will pay for the arrangement or provision of health care services for a Member that would have been Covered Health Care Services except that they were required due to a liable third party, in exchange for the following agreement:

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

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to UnitedHealthcare, which debt shall include the cost of arranging or providing otherwise Covered Health Care Services to the Member for the care and treatment that was necessary because of a liable third party.

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

Non-Duplication of Benefits With Automobile, Accident or Liability Coverage

If you are receiving benefits as a result of automobile, accident or liability coverage, UnitedHealthcare will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected and to notify UnitedHealthcare of such coverage when available. UnitedHealthcare will provide Covered Health Care Services over and above your automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

Subrogation and Reimbursement

Any demand upon a Member will be in accordance with California Civil Code Section 3040.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory for any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Subscriber Agreement, we shall also have an independent right to be reimbursed by you for any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

The following persons and entities are considered third parties:

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the services and benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.

That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

SECTION 7. MEMBER ELIGIBILITY

- **Who is a UnitedHealthcare Member**
- **Adding Family Members to Your Coverage**
- **Late Enrollment**
- **Updating Your Enrollment Information**
- **Termination and Rescission of Coverage**
- **Coverage Options Following Termination**

This section describes how you become a UnitedHealthcare Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your UnitedHealthcare coverage when it would otherwise terminate.

Who is a UnitedHealthcare Member?

There are two kinds of UnitedHealthcare Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or her employer-sponsored health benefit plan. The Employer Group, in turn, has signed a Group Agreement with UnitedHealthcare.

The following Family Members are eligible to enroll in UnitedHealthcare:

1. The Subscriber's legal spouse or Domestic Partner;
2. The biological children of the Subscriber or the Subscriber's legal spouse or the Domestic Partner (stepchildren) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age," see **Definitions**);
3. Children who are legally adopted or placed for adoption with the Subscriber, the Subscriber's legal spouse or the Domestic Partner who are under the Limiting Age established by the employer;
4. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be provided to UnitedHealthcare upon request; and
5. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner is required to provide health insurance coverage according to a qualified medical child support order assignment order, or medical support order, in this section.
6. Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children as determined eligible by the Employer Group.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- Was born to a single person or unmarried couple;
- Is not claimed as a Dependent on a federal income tax return;
- Does not reside with the Subscriber or within the UnitedHealthcare Service Area.

Who is Eligible for Coverage?

All Members must meet all eligibility requirements established by the Employer Group and UnitedHealthcare. UnitedHealthcare's eligibility requirements are:

- Have a Primary Residence within California;
- Have a Primary Residence or Primary Workplace within the Health Plan's Service Area;

- Choose a PCP within 30 miles of his or her Primary Residence or Primary Workplace (except children enrolled due to a qualified medical child support order);
- Meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an Eligible Employee can enroll in UnitedHealthcare. Employers will also establish the Limiting Age, the age limit for providing coverage to children.

Eligible Family Members must enroll in UnitedHealthcare at the same time as the Subscriber or risk not being eligible to enroll until the employer's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to UnitedHealthcare all applications or other forms or statements that UnitedHealthcare may reasonably request.

Enrollment is the completion of a UnitedHealthcare enrollment form (or a nonstandard enrollment form approved by UnitedHealthcare) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by UnitedHealthcare, the existence of a valid Employer Group Agreement, and the timely payment of applicable Health Plan Premiums. UnitedHealthcare may, in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

Effective Date of Coverage for New Subscribers and Family Members to be added outside the Open Enrollment Period

Coverage for a newly enrolled Subscriber and his or her eligible Family Members begins on the date agreed to by the Employer Group or under the terms of the signed Group Agreement provided we receive the completed enrollment form and any required Health Plan Premium within 30 days of the date the Subscriber becomes eligible to enroll in the Health Plan.

The effective date of enrollment when adding Family Members outside of the initial, Special, or Open Enrollment Period is explained below. (**Please Note:** UnitedHealthcare enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.)

What is a Service Area?

UnitedHealthcare is licensed by the California Department of Managed Health Care to arrange for medical and Hospital Services in certain geographic areas of California. These service areas are defined by ZIP codes. Additionally, your Network Medical Group limits services to within 30 miles by road or highway from your Primary Residence or Primary Work Place. Please call our Customer Service department for information about UnitedHealthcare's Service Area.

Open Enrollment

Most Members enroll in UnitedHealthcare during the Open Enrollment Period established by the Employer Group. This is the period of time established by the employer when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefit plan. An Open Enrollment Period extends from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and enrollment is effective based on a date agreed upon by the employer and UnitedHealthcare.

Adding Family Members to Your Coverage

The Subscriber's legal spouse or Domestic Partner and eligible children may apply for coverage with UnitedHealthcare during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your legal spouse or Domestic Partner) because of other Health Plan insurance or group Health Plan coverage, you may be able to enroll yourself and your Dependents in UnitedHealthcare if you and your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward your or your Dependent's other coverage). However, you must request enrollment within 60 days after your or your Dependent's other coverage ends (or after the Employer Group stops contributing toward your or your Dependent's other coverage). In addition, if you have a new Dependent due to assumption of a parent-

child relationship, marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, assumption of a parent-child relationship or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll.) New Family Members may be added outside the Open Enrollment Period if they meet any of the following. To obtain more information, call our Customer Service department.

1. **Getting Married.** When a new legal spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the date of the marriage if we receive a completed application to enroll a legal spouse or child eligible due to marriage within 60 days of the marriage.
2. **Domestic Partnership.** When a new Domestic partner or Domestic Partner's child becomes an eligible Family Member due to a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible due to a domestic partnership must be made within 60 days of the domestic partnership.
3. **Having a Baby**. Newborns are covered for the first 60 days of life. In order for coverage to continue beyond the first 60 days of life, a Change Request Form must be submitted to UnitedHealthcare prior to the expiration of the 60-day period. If you do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth).
4. **Adoption or Placement for Adoption.** Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization form or a relinquishment form, granting Subscriber, Subscriber's legal spouse or Domestic Partner the right to control the health care for the adoptive child, or absent such a document, on the date there exists evidence of the Subscriber's legal spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 60 days of the adoption placement.
5. **Assumption of a Parent-Child Relationship or Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's legal spouse or Domestic Partner has assumed legal guardianship or assumption of a parent-child relationship, the Subscriber must submit a Change Request Form to UnitedHealthcare and for legal guardianship, a certified copy of a court order granting guardianship within 60 days of when the Subscriber, Subscriber's legal spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship or a parent-child relationship.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in UnitedHealthcare) may enroll a child who is eligible to enroll in UnitedHealthcare upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period limitations.

A person having legal custody of a child or a custodial parent who is not a UnitedHealthcare Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling the Customer Service department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the Health Plan ID card, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the date of the court or administrative order provided we receive the completed enrollment form with the court or administrative order attached and any required Health Plan Premium.

Except for Emergency Health Care Services and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the UnitedHealthcare Service Area by the designated Network Medical Group, as chosen by the custodial parent or person having legal custody.

Continuing Coverage for Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Health Plan due to their attainment of the Limiting Age established by UnitedHealthcare may extend their coverage under the following circumstance:

A Dependent residing outside of the Service Area must maintain a permanent address inside the Service Area and must choose a Network Medical Group within 30 miles of that address. All health care coverage must be provided or arranged for in the Service Area by the designated Network Medical Group, except for Emergency Health Care Services and Urgently Needed Services. A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents who attain the Limiting Age may continue enrollment in the Health Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. The unmarried Dependent is chiefly Dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Dependent reaching the Limiting Age, UnitedHealthcare will send notice to you, the Subscriber, that coverage for the disabled Dependent will terminate at the end of the Limiting Age unless proof of such incapacity and dependency is provided to UnitedHealthcare by the Member within 60 days of receipt of notice. UnitedHealthcare shall determine if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until UnitedHealthcare makes a determination.

UnitedHealthcare may require ongoing proof of a Dependent's incapacity and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, UnitedHealthcare may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide UnitedHealthcare with the requested information within 60 days of receipt of the request. The child must have been covered as a dependent of the Subscriber or legal spouse under a previous Health Plan at the time the child reached the age limit.

Late Enrollment

In addition to a special enrollment period due to the addition of a new legal spouse, Domestic Partner or child, there are certain circumstances when Eligible Employees and their eligible Family Members may enroll outside of the employer's Open Enrollment Period. These circumstances include:

1. The Eligible Employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in UnitedHealthcare when they were first eligible because they had other health care coverage;
2. UnitedHealthcare cannot produce a written statement from the Employer Group or Eligible Employee stating that prior to declining coverage, the Eligible Employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with, and signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage with UnitedHealthcare during the initial enrollment period permits the Company to impose, beginning on the date the Eligible Employee (on his or her behalf, or on behalf of any eligible Dependents) elects coverage under the Health Plan, an exclusion of coverage under the Health Plan for a period of 12 months, unless the Eligible Employee or Family Member can show that he or she meets the requirements for late enrollment.

3. The other health care coverage is no longer available due to:
    i. The Eligible Employee or eligible Family Member has exhausted COBRA or Cal-COBRA continuation coverage under another group Health Plan; or
    ii. The termination of employment or reduction in work hours of a person through whom the Eligible Employee or eligible Family Member was covered; or
    iii. The termination of the other Health Plan coverage; or
    iv. The cessation of an employer's contribution toward the Eligible Employee or eligible Family Member coverage; or
    v. The death, divorce or legal separation of a person through whom the Eligible Employee or eligible Family Member was covered.
    vi. The loss of coverage under the Healthy Families Program due to exceeding the program's income or age limits, or loss of no-share-of-cost Medi-Cal coverage; or loss of coverage through the Covered California, California's Health Benefit Exchange; or
    vii. The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or
    viii. The employee or eligible Family Member previously declined coverage under the Health Plan, but the employee or eligible Family Member becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP) or the AIM Program. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date of the determination of subsidy eligibility; or
    ix. The employee or eligible Family Member loses eligibility under Medicare or Children's Health Insurance Program (CHIP), the AIM Program, or the Medi-Cal program; or Covered California, California's Health Benefit Exchange. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date coverage ended.
4. The Court has ordered health care coverage be provided for your legal spouse or minor child.
5. Open Enrollment Period – You may enroll during the Open Enrollment period from November 1 of the preceding calendar year through January 31 of the benefit year, inclusive.
6. Special Open Enrollment Period – You may enroll within 60 days if one of the following events happens to one of your family Members:
    - The person loses Minimum Essential Coverage for a reason other than nonpayment of premium or rescission of coverage.
    - The person gains a Dependent or becomes a Dependent.
    - The person's enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous due to the plan's error, misrepresentation, or inaction.
    - The health coverage issuer violated a material provision of the health care coverage contract.
    - The person becomes eligible for membership due to a permanent move.
    - The person is mandated to be covered as a Dependent according to a valid state or federal court order.
    - The person has been released from incarceration.

- The person was receiving services from a contracting Provider under another health benefit plan for one of the conditions described in the Continuity of Care Conditions as defined in **Section 10: Definitions** and that Provider is no longer a network in the health benefit plan.
- The person is a Member of the reserve forces of the United States military returning from active duty or a Member of the California National Guard returning from active duty services.

If the Eligible Employee or an eligible Family Member meets these conditions, the Eligible Employee must request enrollment with UnitedHealthcare following the termination of the other Health Plan coverage as shown above. UnitedHealthcare may require proof of loss of the other coverage. Enrollment will be effective on the first of the following month if premium is received from the 1st to the 15th of the month. Enrollment will be effective on the first of the second succeeding month for premiums received on the 15th to the end of the month. Notwithstanding the above, coverage shall be effective on the date of birth, adoption, or placement of adoption for a new Dependent child due to birth, adoption, or placement for adoption. Coverage shall be effective on the first day of the month following the date UnitedHealthcare receives the request for special enrollment in the case of a new legal spouse, Domestic Partner or loss of Minimum Essential Coverage.

Notifying You of Changes in Your Plan

Amendments, modifications or termination of the Group Agreement by either the Employer Group or UnitedHealthcare do not require the consent of a Member. UnitedHealthcare may amend or change the Health Plan, including the applicable Premiums, at any time after sending written notice to the Employer Group 60 days prior to the effective date of any amendment or change. Your Employer Group may also change your Health Plan benefits during the contract year. In accordance with UnitedHealthcare's Group Agreement, the Employer Group is obliged to notify Eligible Employees who are UnitedHealthcare Members of any such amendment or modification.

Updating Your Enrollment Information

Please notify your employer and UnitedHealthcare of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see Adding Family Members to Your Coverage. If you wish to change your PCP or Network Medical Group, you may call 1-800-624-8822 or 711 (TTY).

Renewal and Reinstatement (Renewal Provisions)

Your Employer Group's Group Agreement with UnitedHealthcare renews automatically, on a yearly basis, subject to all terms of the Group Agreement. UnitedHealthcare or your Employer Group may change your Health Plan benefits and Premium at renewal. If the Group Agreement is terminated by UnitedHealthcare, reinstatement is subject to all terms and conditions of the Group Agreement. In accordance with UnitedHealthcare's Group Subscriber Agreement, the Employer Group is required to notify Eligible Employees who are UnitedHealthcare Members of any such amendment or modification.

About Your UnitedHealthcare Health Plan Identification (ID) Card

Your UnitedHealthcare Health Plan ID card is important for identifying you as a Member of UnitedHealthcare. Possession of this card does not entitle a Member to services or benefits under this Health Plan. A Member should show this card each time he or she visits a PCP or, upon referral, any other Network Provider.

Important Note: Any person using this card to receive benefits or services for which he or she is not entitled will be charged for such benefits or services. If any Member permits the use of his or her ID card by any other person, UnitedHealthcare may terminate that Member's membership.

Ending Coverage

Usually, your enrollment in UnitedHealthcare terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health benefit plan. Your Employer Group determines the

date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Health Plan is subject to the terms and conditions of the employer's Group Agreement with UnitedHealthcare.

When the Group Agreement between the Employer Group and UnitedHealthcare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by UnitedHealthcare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated at the end of the 30-day grace period. The grace period shall begin no sooner than the first day following the last day of paid coverage. UnitedHealthcare will continue to provide coverage during the grace period. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated, except in the event the Group Agreement is terminated for the nonpayment of Health Plan Premiums. If this happens, UnitedHealthcare will notify you directly of such termination.

Termination and Rescission of Coverage

If payment is not received from your employer, a Notice of Consequences for Nonpayment of Premiums is mailed. UnitedHealthcare will provide the following information:

- The date the premium is due, and information describing the consequences of the failure to pay the premium amount by the due date.
- That the plan shall continue to provide coverage during a 30-day grace period that begins on the first day after the last day of paid coverage.

UnitedHealthcare has the right to terminate your coverage under this Health Plan in the following situations:

- **For Nonpayment of Premiums.** Your coverage may be terminated if the Employer Group did not pay the required Premiums. UnitedHealthcare will mail your employer a Notice of Cancellation for Nonpayment of Premiums and Grace Period, no later than five (5) business days after the last day of paid coverage. The Notice will advise that if premium amount due is not received by UnitedHealthcare no later than the last day of the 30 day grace period, the plan contract will be cancelled effective the day after the last day of the grace period. The notice will include:
  i. Reason for cancellation;
  ii. Effective date of the cancellation;
  iii. The dollar amount due to the plan;
  iv. The date of the last day of paid coverage;
  v. The date the grace period begins and expires;
  vi. The grace period notice requirements;
  vii. The obligations of the Subscriber or Employer Group during the grace period, if any;
  viii. A clear and concise explanation of the right to submit a Request for review to the Director, and,
  ix. Any notice required as to eligibility for reduced cost coverage through Covered California.

The Notice of Cancellation for Nonpayment of Premiums and Grace Period shall be sent no later than 5 business days after the last day of paid coverage.

Reinstatement of the Contract after Cancellation due to Nonpayment of Premiums

If the Group Contract is cancelled for the group's nonpayment of Premiums, the Plan will permit reinstatement of the Group Contract once during any 12 month period if the group pays the amounts owed within 15 days from the date cancellation in the Plan's Notice of Cancellation to the group.

- **For Fraud or Intentional Misrepresentation of a Material Fact by Member.** Your coverage may be rescinded if you intentionally misrepresent a material fact on your enrollment form or commit fraud, which may include, but not be limited to, deception in use of services or facilities of UnitedHealthcare, its Network Medical Group or other health care Providers or intentionally allow another person to do the same or alter a prescription. Rescinding coverage means that the Group Agreement and *Combined Evidence of Coverage and Disclosure Form* are void and that no coverage existed at any time. UnitedHealthcare will send the Employer Group and you a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Managed Health Care.
- **For Fraud or Intentional Misrepresentation of a Material Fact by Employer Group.** Your coverage may be terminated, if your Employer Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of the Group Agreement (including any omissions, misrepresentations, or inaccuracies in the application form) or to the provision of coverage under the Group Agreement. Also, UnitedHealthcare has the right to rescind the Group Agreement back to either: the date of the Group Agreement; or the date of the act, practice or omission, if later. Rescinding coverage means that the Group Agreement and *Combined Evidence of Coverage and Disclosure Form* are void and that no coverage existed at any time. UnitedHealthcare will send the Employer Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Managed Health Care.
- **For Violation of Employer Group's Contribution or Group Participation Requirements.** Your coverage may be terminated if your Employer Group fails to meet the Group Contribution or Group Participation requirements as described in the Group Agreement.
- **For Discontinuance of this Health Plan.** Your coverage may be terminated if UnitedHealthcare decides to cease offering the Health Plan described in this *Combined Evidence of Coverage and Disclosure Form* upon 90 days written notice to the Director of the Department of Managed Health Care, the Employer Group and all Members covered under this Health Plan. If this Health Plan is discontinued, UnitedHealthcare will make all other health plans offered to new group business available to your Employer Group.
- **For Discontinuance of All New and Existing Health Plans.** Your coverage may be terminated if UnitedHealthcare decides to cease offering existing or new health plans in the group market in the State of California upon 180 days written notice to the Director of the Department of Managed Health Care, the Employer Group and all Members covered under this Health Plan.

If you believe your policy or coverage has been or will be wrongly canceled, rescinded or not renewed, please refer to "**Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan"** in **Section 8. Overseeing Your Health Care Decisions** to learn how to request a review by the Department of Managed Care (DMHC) Director.

Other Reasons for Termination of Coverage Related to Loss of Eligibility

In addition to terminating the Group Agreement, UnitedHealthcare may terminate a Member's coverage for any of the following reasons related to loss of eligibility:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or UnitedHealthcare.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the State of California.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the UnitedHealthcare Service Area and does not work

inside the UnitedHealthcare Service Area (except for a child subject to a qualified child medical support order, for more information refer to Qualified Medical Child Support Order in this section).

If a group agreement is terminated for a material violation relating to employer contribution or participation requirements as set forth in the group agreement, Unitedhealthcare will accord a 30 day prior notice to the Employer Group.

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to Total Disability). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, call our Customer Service department.

Note: If a Group Agreement is terminated by UnitedHealthcare, reinstatement with UnitedHealthcare is subject to all terms and conditions of the Group Agreement between UnitedHealthcare and the employer.

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there is a divorce, the legal spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they reach the Limiting Age established by UnitedHealthcare and do not qualify for extended coverage as a Dependent or as a disabled Dependent. Please refer to the section, Continuing Coverage for Certain Disabled Dependents. It may also end when a Dependent child reaches the Limiting Age. Please refer to Extending Your Coverage for additional coverage which may be available to you.

Total Disability

If the Group Agreement providing the Subscriber coverage is terminated, and the Subscriber or any enrolled Family Members are Totally Disabled on the date the Group Agreement is terminated, federal law may require the group's succeeding carrier to provide coverage for the treatment of the condition causing Total Disability. However, in the event that the Subscriber's group does not contract with a succeeding carrier for health coverage, or in the event that federal law would allow a succeeding carrier to exclude coverage of the condition causing the Total Disability for a period of time, UnitedHealthcare will continue to provide benefits to the Subscriber or any enrolled Family Member for Covered Health Care Services directly relating to the condition causing Total Disability existing at the time of termination, for a period of up to 12 successive months after the termination. The extension of benefits may be terminated by UnitedHealthcare at such time the Member is no longer Totally Disabled, or at such time as a succeeding carrier is required by law to provide replacement coverage to the Totally Disabled Member without limitation as to the disabling condition.

Coverage Options Following Termination

If your coverage through this *Combined Evidence of Coverage and Disclosure Form* ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Health Plan at group rates, plus an administration fee, in certain instances where your coverage under the Health Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group Health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if coverage under the group Health Plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable premiums.

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

- Your hours of employment are reduced to less than the number of hours required for eligibility, or
- Your employment ends for any reason other than gross misconduct on your part.

If you are the legal spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Health Plan because any of the following qualifying events happens:

1. Your legal spouse dies;
2. Your legal spouse's hours of employment are reduced to less than the number of hours required for eligibility;
3. Your legal spouse's employment ends (for reasons other than his or her gross misconduct);
4. Your legal spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your legal spouse.

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage if group health coverage under this Health Plan is lost because any of the following qualifying events happens:

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;
3. Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscribers become divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

When is COBRA Coverage available?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has happened. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, legal spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Health Plan), the Subscriber or enrolled Family Member

has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event happens. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

How is COBRA Coverage provided?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has happened, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Under federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. The date coverage ends due to a qualifying event; or
2. The date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Health Plan may elect COBRA continuation coverage on behalf of their legal spouses and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the Subscriber's divorce or legal separation, or a Dependent child losing eligibility as a Dependent child under this Health Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his legal spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total limit of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the legal spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a limit of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the legal spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the legal spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not happened.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA May Terminate Before Limit Coverage Period Ends.

Under COBRA, the continuation coverage may terminate before the limit coverage period if *any* of the following events happen:

1. Your Employer Group no longer provides group health coverage to any of its Eligible Employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group Health Plan;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

COBRA Premium

Under the law, you may have to pay all of the premium for your continuation coverage. Premiums for COBRA continuation coverage is generally 102 percent of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150 percent of the applicable Premium. You are responsible for the timely submission of the COBRA premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to UnitedHealthcare.

What to Do If You Have Questions About COBRA?

If you have any questions about your COBRA continuation coverage rights, please contact your Employer Group.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated Eligible Employees currently working at your former employment. A notice will be provided to you by UnitedHealthcare at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify UnitedHealthcare within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from UnitedHealthcare. If you fail to notify UnitedHealthcare within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which happened last. Your request must be in writing and delivered to UnitedHealthcare by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by UnitedHealthcare. You must pay your initial Premiums to UnitedHealthcare within 45 days from the date UnitedHealthcare mails your enrollment package

after you notified UnitedHealthcare of your intent to enroll. Your first Premium must equal the full amount billed by UnitedHealthcare. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to UnitedHealthcare by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her Eligible Employees; or
4. You no longer meet eligibility for UnitedHealthcare coverage, such as moving outside the UnitedHealthcare Service Area; or
5. The contract for health care services between your employer and UnitedHealthcare is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension due to disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to UnitedHealthcare within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with UnitedHealthcare coverage, you may continue the remaining balance of your unused coverage with UnitedHealthcare, but only if you enroll with and pay Premiums to UnitedHealthcare within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and UnitedHealthcare terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Cal-COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the California Continuation Benefits Replacement Act (Cal-COBRA), you may be entitled to temporarily extend your coverage for up to 36 months, based upon 110 percent of your former employer's Health Plan group rates in certain instances where your coverage under the Health Plan would otherwise end. In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Subscriber will pay 150 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to the month in which the Subscriber becomes entitled to Medicare, but not to exceed 36 months.

Cal-COBRA only applies when Subscriber's former employer has two to 19 Eligible Employees who are not covered or eligible for federal COBRA coverage. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under Cal-COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under Cal-COBRA. And if your former Employer Group later qualifies for federal COBRA benefits and coverage, once you are enrolled on Cal-COBRA, your benefits will continue under Cal-COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of Cal-COBRA continuation coverage.

Cal-COBRA Qualifying Events for Subscribers

If you are a Subscriber covered by this Health Plan, you have a right to choose Cal-COBRA continuation coverage if you lose your group health coverage because of an initial qualifying event, described as:

1. The termination of your employment (for reasons other than gross misconduct on your part); or
2. The number of hours you work on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by your employer.

Additionally, if you are determined to be disabled under Title II or Title XVI of the United States Social Security Act within 60 days of your initial qualifying event, you must notify your former employer of this determination within 60 days of the date of the determination letter and prior to the 36th month of Cal-COBRA coverage. You are required to pay to UnitedHealthcare 150 percent of the group rate after the first 18 months and up to the month in which you become entitled to Medicare, but not to exceed a combined total of 36 months. Your coverage under Cal-COBRA will end upon your Medicare entitlement. In the event the Social Security Administration determines that you are no longer disabled, you have 30 days from the date of the determination letter to contact UnitedHealthcare of this decision. Your termination date will be the later of 36 months from the date of your initial qualifying event or the first of the month following 31 days from the date of the final Social Security Administration determination.

Cal-COBRA Qualifying Events for Legal Spouses

If you are the legal spouse of a Subscriber covered by this Health Plan, you have the right to choose Cal-COBRA continuation coverage for up to 36 months based upon 110 percent of the Subscriber's former employer's Health Plan group rates for yourself if you lose group health coverage under this Health Plan for *any* of the following four reasons (also called a qualifying event):

- The death of the Subscriber;
- A termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in the Subscriber's number of hours worked are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the employer;
- Divorce or legal separation from the Subscriber; or
- The Subscriber becomes entitled to Medicare. (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the legal spouse will pay 110 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group Health Plan coverage, the legal spouse may have up to 36 months based upon 110 percent of the Subscriber's former employer's Health Plan group rates).

Cal-COBRA Qualifying Events for Dependent Children

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage for up to 36 months based upon 110 percent of the Subscriber's former employer's Health Plan group rates if group health coverage under this Health Plan is lost for *any* of the following five reasons (also called a qualifying event):

- The death of the Subscriber;
- A termination of the Subscriber's employment (for reasons other than gross misconduct) or the number of the Subscriber's hours are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the employer;
- The Subscriber's divorce or legal separation;
- The Subscriber becomes entitled to Medicare; (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the dependent will pay 110 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group Health Plan coverage, the dependent may have up to 36 months based upon 110 percent of the Subscriber's former employer's Health Plan group rates); or

- The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

Cal-COBRA Notification of Qualifying Events

Under Cal-COBRA, as a condition of receiving Cal-COBRA benefits, the Member must provide UnitedHealthcare with written notification of the occurrence of the following qualifying events within 60 days of the occurrence of the event:

- The Subscriber's death;
- Divorce or legal separation;
- The loss of Dependent status; or
- The covered employee's entitlement to Medicare.

Cal-COBRA Enrollment and Premium Information

It is your responsibility to notify UnitedHealthcare of the occurrence of any of the above Qualifying Events within 60 days, except that your employer must notify UnitedHealthcare within thirty (30) days of the occurrence of a termination of employment or the number of hours you work on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by your employer, which would result in loss of coverage under your group benefit plan. Your failure to notify UnitedHealthcare of the occurrence of a Qualifying Event within sixty will disqualify you from receiving continuation coverage.

Members may contact UnitedHealthcare for a copy of the Qualifying Event Notification Form which should be used to notify UnitedHealthcare. All notifications must be submitted to UnitedHealthcare in writing at the following address:

UnitedHealthcare of California
Membership Accounting, MS-CA 120-0515
5701 Katella Avenue
Cypress, CA 90630

Within fourteen (14) days of receiving written notice of a qualifying event, UnitedHealthcare will send Cal-COBRA enrollment and premium information to you. A Member who wishes to elect Cal-COBRA continuation coverage must request the continuation coverage in writing and deliver the written request, by first-class mail, or other reliable means of delivery, to UnitedHealthcare within the 60 day period following the later of:

1. The date that the Member's coverage under the Group Agreement terminated or will terminate by reason of the qualifying event; or
2. The date the enrollee was sent Cal-COBRA enrollment and premium information.

Failure to elect Cal-COBRA coverage within the 60-day period will disqualify the Member from Cal-COBRA coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end and you will be financially responsible for any health care services that you have received after your terminating event, under the Cal-COBRA Health Plan.

If you choose continuation coverage, your former Employer Group is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Eligible Employees or family Members. Cal-COBRA permits you to maintain continuation coverage for up to 36 months. If the Social Security Administration determines you to be disabled at any time during the first 60 days of Cal-COBRA, Cal-COBRA allows you to maintain continuation coverage up to your Medicare entitlement, but not to exceed a combined total of 36 months. Please contact your Employer Group or UnitedHealthcare for more information regarding Cal-COBRA continuation coverage.

A child who is born to or placed for adoption with the eligible Subscriber during a period of Cal-COBRA continuation coverage will also be eligible to enroll as a Cal-COBRA qualified beneficiary. These Cal-COBRA qualified beneficiaries can be added to your Cal-COBRA continuation coverage upon proper notification to UnitedHealthcare of the birth or adoption. Please call UnitedHealthcare at 1-800-591-9911 to start the enrollment process of your new child. A Change Form will be mailed to you along with your new premium information. The Change Form must be received within 30 days of the child's birth or placement for adoption.

Termination of Cal-COBRA Continuation Coverage

However, under Cal-COBRA, the continuation coverage may be cut short for *any* of the following four reasons:

- Your former Employer Group no longer provides group health coverage to any of its Eligible Employees;
- The premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered after the date he or she elects Cal-COBRA continuation coverage under another group Health Plan; or
- The qualified beneficiary becomes entitled to Medicare after the date he or she elects Cal-COBRA continuation coverage.

For Cal-COBRA, you are responsible for paying the Health Plan Premium directly to UnitedHealthcare on a monthly basis and it must be delivered by first-class mail or other reliable means. The first month's Cal-COBRA Health Plan Premium payment is due within 45 days of the date that you submit the Cal-COBRA election form to UnitedHealthcare. This payment must be sufficient to pay all premiums due from the first month after the qualifying event through the current month. Failure to submit the correct premium amount will disqualify you from receiving Cal-COBRA continuation coverage. Thereafter, Cal-COBRA premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). Your Cal-COBRA premium will generally be 110 percent of the premium charged to your employer for similarly active employees. Your premium may be increased or your benefits decreased each time your former Employer's Group benefit package renews or changes. Please note you will not be enrolled in Cal-COBRA until UnitedHealthcare receives both your Cal-COBRA election form and your first Cal-COBRA premium payment. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the Medicare-entitled qualified beneficiary is required to pay to UnitedHealthcare 150 percent of the group rate after the first 18 months to the month in which they become Medicare entitled, but not to exceed 36 months. At the end of the 36-month continuation coverage period, qualified beneficiaries may enroll in Covered California, California's Health Benefit Exchange, unless you are eligible for Medicare. (Other exclusions may apply. Please see the explanation under Extending Your Coverage: Converting to an Individual Plan.)

If the contract between the Subscriber's Employer Group and UnitedHealthcare terminates prior to the date your continuation coverage would terminate under Cal-COBRA, you may elect continuation coverage under the subsequent benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan. However, continuation coverage will terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of premiums to the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

If you have any questions about Cal-COBRA, please contact UnitedHealthcare or your former Employer Group.

1401 Extended Continuation Coverage After Cal-COBRA

In the event your Cal-COBRA coverage began on or after January 1, 2003, and you have used all of your Cal-COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated Eligible Employees currently working at your former employment. A notice will be provided to you by UnitedHealthcare at the time your Cal-COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your

California Continuation COBRA benefits will not exceed a combined total of 36 months from the date Cal-COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your Cal-COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between Cal-COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After Cal-COBRA

You must notify UnitedHealthcare within 60 days from the date your Cal-COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from UnitedHealthcare. If you fail to notify UnitedHealthcare within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after Cal-COBRA. The 60-day period will be counted from the event which occurred last. Your request must be in writing and delivered to UnitedHealthcare by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by UnitedHealthcare. You must pay your initial Premiums to UnitedHealthcare within 45 days from the date UnitedHealthcare mails your enrollment package after you notified UnitedHealthcare of your intent to enroll. Your first Premium must equal the full amount billed by UnitedHealthcare. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to UnitedHealthcare by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll in Cal-COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA, even if you enroll in UnitedHealthcare on or after January 1, 2003. Your qualifying event is the first day in which you were initially no longer eligible for your group Health Plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of 1401 Extended Continuation Coverage After Cal-COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her Eligible Employees; or
4. You no longer meet eligibility for UnitedHealthcare coverage, such as moving outside the UnitedHealthcare Service Area; or
5. The contract for health care services between your employer and UnitedHealthcare is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension due to disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from the date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to UnitedHealthcare within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with UnitedHealthcare coverage, you may continue the remaining balance of your unused coverage with UnitedHealthcare, but only if you enroll with and pay Premiums to UnitedHealthcare within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and UnitedHealthcare terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation

coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States' uniformed services, up to the maximum 24 month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA or Cal-COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must choose a Network Medical Group within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Network Medical Group, except for Emergency Health Care Services and Urgently Needed Services.

The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other UnitedHealthcare Members enrolled through your employer plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Health Plan Premiums from you or your Dependents and will forward your Health Plan Premiums to UnitedHealthcare along with your employer's Health Plan Premiums otherwise due under this Agreement. Additionally, your employer is responsible for maintaining accurate records regarding USERRA continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for UnitedHealthcare to administer this continuation benefit.

California Military Families Financial Relief Act

Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for Pre-Existing Conditions. Please call Member Services for information on how to apply for reinstatement of coverage following active duty as a reservist.

SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

- **How does UnitedHealthcare Make Important Health Care Decisions**
- **What to Do if You Have a Problem**
- **Filing a Grievance**
- **Appeals and Grievance Process**
- **Independent Medical Review**

This section explains how UnitedHealthcare authorizes or makes changes to your health care services, how we evaluate new health care technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your health care plan, including how to appeal a health care decision by UnitedHealthcare or one of our Network Providers. You will learn the process that is available for filing a formal Grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How Does UnitedHealthcare Make Important Health Care Decisions?

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may take place by UnitedHealthcare, or in many situations, by a Network Medical Group. Processes are used to review, approve, modify or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

Medical Necessity refers to an intervention as defined in **Section 10: Definitions**. A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

The reviewer may also use criteria or guidelines to determine whether to approve, modify or deny, based on Medical Necessity, requests by Providers of health care services for Members. The criteria used to modify or deny requested health care services in specific cases will be provided free of charge to the Provider, the Member and the public upon request.

Decisions to deny or modify requests for authorization of health care services for a Member, based on Medical Necessity, are made only by licensed Physicians or other appropriately licensed health care professionals.

The reviewer makes these decisions within at least the following time frame required by state law:

- Decisions to approve, modify or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five business days from UnitedHealthcare's or, in many situations, the Network Medical Group's receipt of the information reasonably necessary and requested to make the decision.
- If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be harmful in regaining maximum function or to the Member's life or health, the decision will be provided in a timely fashion appropriate for the nature of the Member's condition, but not later than 72 hours after UnitedHealthcare's or, in many situations, the Network Medical Group's receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frame because of the following:

- UnitedHealthcare or, in many situations, the Network Medical Group is not in receipt of all of the information reasonably necessary and requested; or
- Consultation by an expert reviewer is required; or

- UnitedHealthcare or the Network Medical Group has asked that an additional exam or test be performed on the Member, provided the exam or test is reasonable and consistent with good medical practice, the reviewer will notify the Provider and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as the reviewer becomes aware that it will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the expected date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by UnitedHealthcare or the Network Medical Group, the reviewer shall approve, modify or deny the request for authorization within the time frame shown above as applicable.

The reviewer will notify requesting Providers of decisions to approve, modify or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny or modify requested health care services, in writing, within two business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with UnitedHealthcare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. UnitedHealthcare's appeals process is outlined in this section.

UnitedHealthcare's Utilization Management Policy

UnitedHealthcare distributes its policy on financial incentives to all its Network Providers, Members and Eligible Employees. UnitedHealthcare also requires that Network Providers and staff who make utilization decisions, and those who supervise them, sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. UnitedHealthcare does not specifically reward Network Providers or other persons conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not suggest decisions that result in either the denial or modification of Medically Necessary Covered Health Care Services.

Medical Management Guidelines

The Medical Management Guidelines Committee (MMGC), consisting of UnitedHealthcare Medical Directors, provides a forum for the development, review and adoption of medical management guidelines to support consistent, appropriate medical care determinations. The MMGC develops guidelines using evidence-based medical literature and documents related to medical treatment or service. The Medical Management Guidelines contain practice and utilization criteria for use when making coverage and medical care decisions prior to, subsequent to or concurrent with the provisions of health care services.

Technology Assessment

UnitedHealthcare regularly reviews new procedures, devices, and drugs to determine whether or not they are safe and effective for our Members. New procedures and technology that are safe and effictive are eligible to become Covered Health Care Services. If the technology becomes a Covered Health Care Service, it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Co-payments/Deductibles, or other payment contributions.

In determining whether to cover a service, UnitedHealthcare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and effictiveness of a new technology or new application of an existing technology for an individual Member, a UnitedHealthcare Medical Director makes a Medical Necessity determination based on individual Member medical documentation, review of published scientific evidence and, when appropriate, seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Utilization Criteria

When a Provider or Member requests Prior Authorization of a procedure/service requiring Prior Authorization, an appropriately qualified licensed health professional reviews the request. The qualified licensed health professional applies the applicable criteria, including, but not limited to:

- Nationally published guidelines for utilization management (specific guideline information available upon request);
- HCIA-Sachs Length of Stay© Guidelines (average length of hospital stays by medical or surgical diagnoses);
- UnitedHealthcare Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP). (*UnitedHealthcare's Medical Management Guideline Manual* and *Commercial HMO Benefit Interpretation Policy Manual* are available at **www.myuhc.com**.)

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Network Medical Group's Medical Director or a UnitedHealthcare Medical Director.

Denial or modification of health care services based on Medical Necessity must be made by an appropriately qualified licensed Physician or a qualified licensed health professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.

Denials may be made for reasons other than Medical Necessity that include, but are not limited to, the fact that the patient is not a UnitedHealthcare Member or that the service being requested is not a benefit provided by the Member's plan.

Prior Authorization determinations are made once UnitedHealthcare or Member's Network Medical Group Medical Director or designee receives all reasonably necessary medical information. UnitedHealthcare makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with state and federal requirements.

Prior authorization is not required for FDA-approved biomarker testing for:

- An enrollee with advanced or metastatic stage 3 or 4 cancer.
- Cancer progression or recurrence in an enrollee with advanced or metastatic stage 3 or 4 cancer.

Prior authorization, utilization management or utilization review are not required for Abortion and abortion-related services.

What to Do if You Have a Problem

Sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We will help you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section 2. Seeing the Doctor or Other Providers and Timely Access To Care**.

If you feel that your problem is not resolved or that your situation requires additional action, you may also submit a Grievance requesting an Appeal or Quality Review. To learn more about this, read the following section: "Appealing a Health Care Decision or Requesting a Quality of Care Review."

Filing a Grievance

To begin a quality of care review or other type of grievance, or for other questions relating to filing a grievance, including but not limited to those involving discrimination, call our Customer Service department at 1-800-624-8822 or at www.myuhc.com. A Customer Service representative will document your oral grievance.

You may also file a grievance using the Online Grievance form at **www.myuhc.com** or write to the Appeals department at:

Appeals & Grievances
UnitedHealthcare
P.O. Box 6107
Mailstop CA124-0160
Cypress, CA 90630-9972

This request will begin the following Grievance Review Process except in the case of "expedited reviews", as discussed below. You may submit written comments, documents, records and any other information relating to your grievance regardless of whether this information was submitted or considered in the initial determination.

After receipt of your grievance:

- We will provide for a written acknowledgment within five calendar days of the receipt of your grievance. The acknowledgment shall provide you with the following information:
- That the grievance has been received.
- The date of receipt
- The name of the Plan representative and the telephone number and address of the Plan representative who may be contacted about the grievance.

You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

All quality of clinical care and quality of service complaints are investigated by UnitedHealthcare's health services department. UnitedHealthcare conducts this quality review by investigating the complaint and consulting with your Network Medical Group, treating Providers, and other UnitedHealthcare internal departments. Medical records are requested and reviewed as needed, and as such, you may need to sign an authorization to release your medical records. We will respond to your complaint in a manner appropriate to the clinical urgency of your situation. You will also receive written notification regarding the disposition of your quality of clinical care and/or quality of service review complaint within 30 calendar days of UnitedHealthcare's receipt of your complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in agreement with state law.

After participating in UnitedHealthcare's grievance process for 30 days, you can also file a complaint with the California Department of Managed Health Care (DMHC).

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your Health Plan, you should first telephone your Health Plan at 1-800-624-8822 or 711 (TTY) and use your Health Plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your Health Plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for help. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing-and speech-impaired. The department's internet website http://www.dmhc.ca.gov has Complaint forms, IMR application forms and instructions online.

Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan

If you believe that your Health Plan enrollment or subscription has been, or will be improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal. You also have the right to submit a request to the Director of the Department of Managed Health Care to review your cancellation.

First, file your complaint with UnitedHealthcare

- You can file a complaint with UnitedHealthcare by contacting our Customer Service department at 1-800-624-8822 or by visiting **www.myuhc.com**.
- You should file your complaint as soon as possible after you receive notice that your Health Plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent, UnitedHealthcare must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, UnitedHealthcare must give you a decision within 30 days.

Take your complaint to the California Department of Managed Health Care (DMHC)

The DMHC oversees HMOs and other Health Plans in California and protects the rights of HMO Members. You can file a complaint with the DMHC if:

- You are not satisfied with UnitedHealthcare's decision about your complaint, or;
- You have not received the decision within 30 days, or within 3 days if the problem is urgent.
- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with UnitedHealthcare, if the DMHC determines that your problem requires immediate review.

For Help
Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive assistance with this process, or submit an inquiry in writing to the **DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website: **http://www.dmhc.ca.gov**. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-877-688-9891 (TTY).**

If you have a complaint or grievance relating to Mental Health and Substance-Related and Addictive Disorder Services, you can submit it to USBHC, see the behavioral health supplement to your Combined Evidence of Coverage and Disclosure Form for USBHPC.

If you have a complaint or grievance relating to pediatric dental and/ or vision services, you may file by calling the Customer Service department at 1-800-624-8822, or by visiting www.myuhc.com, or by writing a complaint/ grievance at:

Appeals & Grievances
UnitedHealthcare
P.O. Box 6107
Mailstop CA124-0160
Cypress, CA 90630-9972

Complaints or grievances relating to acupuncture and/ or chiropractic services (if purchased), will be filed and handled by the ACN Group of California d/b/a OptumHealth Physical Health of California, see the *Schedule of Benefits* for acupuncture and/ or chiropractic services, if any, for more information.

Concurrent Care Review

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 Request for Benefits, 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. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request. Notification will include a description of the criteria and guidelines used to make the decision and be provided to you and your Provider.

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 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. Notification will include a description of the criteria and guidelines used to make the decision and be provided to you and your Provider.

We will provide continued coverage pending the outcome of an appeal. We will not reduce or terminate an ongoing course of treatment without providing advance notice, an opportunity for advance review and a care plan, and a medically appropriate treatment plan agreed between UnitedHealthcare and the treating Provider.

The reviewer will notify requesting Providers of decisions to approve, modify or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny or modify requested health care services, in writing, within two business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with UnitedHealthcare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. UnitedHealthcare's Appeals Process is outlined in this section.

The Appeals Process

You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals department. UnitedHealthcare’s health services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of UnitedHealthcare’s receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, UnitedHealthcare’s written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Health Care Services, the response will specify the provisions in the *Combined Evidence of Coverage and Disclosure Form* that exclude that coverage.

You may submit a grievance or complaint, obtain complaint forms or other information relating to acupuncture and chiropractic services, pediatric dental and pediatric vision services. For more information on each of these benefits, please go to www.myuhc.com or call the Customer Service Department at 1-800-624-8822 or refer to the supplements to the Combined Evidence of Coverage that will be provided to you for each of these benefits.

To begin an appeal, contact our Customer Service department at 1-800-624-8822, where a Customer Service representative will document your oral appeal. You may also file an appeal using the online Grievance form at **www.myuhc.com** or write to the Appeals department at:

Appeals & Grievances
UnitedHealthcare
P.O. Box 6107
Mailstop CA124-0160
Cypress, CA 90630-9972

In addition, you may request a review by the California Department of Managed Care ("DMHC") Director if you believe your policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive help with this process, or submit an inquiry in writing to the **DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website: **http://www.dmhc.ca.gov**. The hearing-and speech-impaired may use the California Relay Service's toll-free telephone number **1-877-688-9891 (TTY).**

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your Health Plan, you should first telephone your Health Plan at 1-800-624-8822 or 711 (TTY) and use your Health Plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your Health Plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDHI line **(1-877-688-9891)** for the hearing-and speech-impaired. The department's internet website **http://www.dmhc.ca.gov** has Complaint forms, IMR application forms and instructions online.

Patient Protection and Affordable Care Act (PPACA) – Changes provided for under the PPACA may impact how appeals are handled and are applicable to your Health Plan.

- An Adverse Benefit Determination includes a decision to rescind coverage. You may submit an appeal for a rescission of coverage determination or a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department.
- You may submit an appeal for any Adverse Benefit Determination as defined in Section 10. Definitions.
- If any new or additional evidence is relied upon or generated by UnitedHealthcare or the Network Medical Group during the determination of an appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

Expedited Review Appeals Process

Appeals involving an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to UnitedHealthcare's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, UnitedHealthcare will immediately inform you of your review status and your right to notify the Department of Managed Health Care (DMHC) of the Grievance.

You and the DMHC will be provided a written statement of the disposition or pending status of the expedited review no later than three calendar days from receipt of the Grievance. You are not required to participate in the UnitedHealthcare appeals process prior to contacting the DMHC regarding your expedited appeal.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with UnitedHealthcare's Appeal Process determination, you can request that UnitedHealthcare submit the appeal to voluntary mediation or binding arbitration before JAMS.

Voluntary Mediation

In order to begin voluntary mediation, either you or the agent acting on your behalf must submit a written request to UnitedHealthcare. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

Binding Arbitration

All disputes of any kind, including, but not limited to, claims relating to the delivery of services under the plan and claims for medical malpractice between the Member (including any heirs, successors or assigns of Member) and UnitedHealthcare, except for claims subject to ERISA, will be submitted to Binding Arbitration. Medical malpractice includes any issues or allegations that medical services provided under the Health Plan were unnecessary or unauthorized or were improperly, negligently or incompetently provided. This means that disputes between the Member and UnitedHealthcare will not be resolved by a lawsuit or by pursuing other court processes and remedies, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Under this provision, neither the Court nor any arbitrator may delay arbitration of disputes or refuse to order disputes to arbitration. The intent of this arbitration provision, and the parties, is to put litigation on hold so that issues can be resolved through the binding arbitration process. Any disputes about the scope of arbitration, about the arbitration itself or about whether an issue falls under this arbitration provision will be resolved by the arbitrator to avoid ambiguities and litigation costs.

The Member and UnitedHealthcare understand and agree that they are giving up their constitutional rights to have disputes decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator. The arbitration will be performed by JAMS or another arbitration service as the parties may agree in writing. The arbitration will be conducted under the JAMS Comprehensive Arbitration Rules and Procedures. The parties will attempt in good faith to agree to the appointment of an arbitrator, but if agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator will be chosen using the appointment procedures set out in the JAMS Comprehensive Arbitration Rules and Procedures. These rules may be viewed by the Member at the JAMS website, **www.jamsadr.com**. If the Member does not have access to the Internet, the Member may request a copy of the rules from UnitedHealthcare, and arrangements will be made for the Member to obtain a hard copy of the rules and procedures.

Arbitration hearings will be held in Orange County, California, or at a location agreed to in writing by the Member and UnitedHealthcare. The expenses of JAMS and the arbitrator will be paid in equal shares by the Member and UnitedHealthcare. Each party will be responsible for any the expenses related to discovery conducted by them and their own attorney fees. In cases of extreme hardship, UnitedHealthcare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and JAMS approves the application. The approval or denial of the hardship application will be determined solely by JAMS. The Member will remain responsible for their own attorney fees, unless an award of attorney fees is allowable under the law and the arbitrator makes an award of attorney fees to the Member. Following the arbitration, the arbitrator will prepare a written award that includes the legal and factual reasons for the decision.

Nothing in this Binding Arbitration provision is intended to prevent the Member or UnitedHealthcare from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court. However, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, will be subject to this Binding Arbitration provision. Any claim for permanent injunctive relief will be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, will apply to the arbitration.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED IN COURT BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION.

Experimental or Investigational Treatment

A UnitedHealthcare medical director may deny a treatment if he or she determines it is Experimental or Investigational, except as described in Clinical Trials under **Section 5. Your Medical Benefits**. If you have a terminal illness, as defined below, you may request that UnitedHealthcare hold a conference within 30 calendar days of receiving your request to review the denial. For purposes of this paragraph, terminal illness means an incurable or irreversible condition that has a high probability of causing death. The conference will be held within five days if the treating Physician determines, in consultation with the UnitedHealthcare Medical Director and based on professionally recognized standards of practice, that the effectiveness of the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Independent Medical Review

If you believe that a health care service included in your coverage or dental services have been improperly denied, modified or delayed by UnitedHealthcare or one of its Network Providers, you may request an Independent Medical Review (IMR) of the decision. IMR is available for denials, delays or modifications of health care services or dental services requested by you or your Provider based on a finding that the requested service is Experimental or Investigational or is not Medically Necessary. Your case also must meet the statutory eligibility criteria and procedural requirements discussed below. If your Complaint or appeal pertains to a Disputed Health Care Service or Dental Service subject to Independent Medical Review (as discussed below), you must file your Complaint or appeal within 180 calendar days of receiving a denial notice.

Eligibility for Independent Medical Review

Experimental or Investigational Treatment Decisions

If you suffer from a life-threatening or seriously debilitating condition, you may have the opportunity to seek IMR of UnitedHealthcare's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4.

Life-Threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Physician certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
    - Standard therapies have not been effective in improving your condition; or
    - Standard therapies would not be medically appropriate for you; or
    - There is no more beneficial standard therapy covered by UnitedHealthcare than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.

2. Your UnitedHealthcare Network Physician has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Physician in certifying his or her recommendation; or you or your non-contracting Physician – who is a licensed, board-certified or board-eligible Physician qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence shown in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To meet this requirement, the Physician certification must include a statement detailing the evidence relied upon by the Physician in certifying his or her recommendation. (**Please note** that UnitedHealthcare is not responsible for the payment of services provided by Out-of-Network Physicians who are not otherwise covered under your UnitedHealthcare benefits.)
3. A UnitedHealthcare Medical Director has denied your request for a treatment or therapy recommended or requested according to the above paragraph.
4. The treatment or therapy recommended according to Paragraph 2 above would be a Covered Health Care Service, except for UnitedHealthcare's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and UnitedHealthcare denies your request for Experimental or Investigational therapy, UnitedHealthcare will send a written notice of the denial within five business days of the decision. The notice will advise you of your right to request IMR, and include a Physician certification form and an application form with a self addressed envelope to be used to request IMR from the DMHC.

Disputed Health Care Services or Dental Services

You may also request IMR of a Disputed Health Care Service or Dental Services. A Disputed Health Care Service or Dental Services areany health care service or dental service eligible for coverage and payment under your Health Plan that has been denied, modified or delayed in whole or in part by UnitedHealthcare or one of its Network Providers due to a finding that the service is not Medically Necessary. (**Note:** Disputed Health Care Services or Dental Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny health care services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your health care coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Health Care Service or Dental Service if you meet all of the following criteria:

1. Your Provider has recommended a health care service as Medically Necessary; or you have received Urgently Needed Services or Emergency Health Care Services that a Provider determined were Medically Necessary; or you have been seen by a Network Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The health care service or dental service have been denied, modified or delayed by UnitedHealthcare or one of its Network Providers; and
3. You have filed an appeal with UnitedHealthcare regarding the decision to deny, delay or modify health care services or dental services and the disputed decision is upheld or the appeal remains unresolved after 30 calendar days (or three calendar days in the case of an urgent appeal requiring expedited review). (**Note:** If there is an imminent and serious threat to your health, the DMHC may waive the requirement that you complete the appeals process or take part in the appeals process for at least 30 calendar days if the DMHC determines that an earlier review is needed.)

You may apply to the DMHC for IMR of a Disputed Health Care Service or Dental Services within six months of any of the events or periods described above, or longer if the DMHC determines that the circumstances of your case warrant an IMR review. UnitedHealthcare will provide you an IMR application form with any Grievance

disposition letter that denies, modifies or delays, in whole or in part, health care services or dental services based on a finding that the service is not Medically Necessary. A decision not to take part in the IMR process may cause you to forfeit any statutory right to pursue legal action against UnitedHealthcare regarding the Disputed Health Care Service or Dental Services. The IMR process is in addition to any other procedures or remedies that may be available to you.

Independent Medical Review Procedures

Applying for Independent Medical Review Procedures

In the case of Experimental or Investigational coverage decisions, if you have a Life-Threatening or Seriously Debilitating condition, UnitedHealthcare will include an application for IMR in our notice to you that the requested service has been denied and include a Physician certification form with a self addressed envelope to the DMHC. Your Physician must provide the Physician certification and medical and scientific documentation required for Experimental and Investigational IMR, which may be included with your application, or mailed or faxed directly to the DMHC by your Physician. Either you or your Physician can provide the letter from UnitedHealthcare or its Network Provider denying the request for Experimental or Investigational treatment.

In the case of determinations that a Disputed Health Care Service or Dental Services are not Medically Necessary, UnitedHealthcare will provide you with an IMR application form with any disposition letter resolving your appeal of the determination. Your application for IMR of a Disputed Health Care Service or Dental Services may include information or documentation regarding a Provider's recommendation that the service is Medically Necessary, medical information that a service received on an urgent care or emergency basis was Medically Necessary, and any other information you received from or gave to UnitedHealthcare or its Network Providers that you believe is relevant in support of your position that the Disputed Health Care Service or Dental Services were Medically Necessary.

Completed applications for IMR should be submitted to the DMHC. You pay no fee to apply for IMR. You, your Physician, or another designated representative acting on your behalf may request IMR. If there is any additional information or evidence you or your Physician wish to submit to the DMHC that was not previously provided to UnitedHealthcare, you may include this information with the application for IMR. The DMHC fax number is (916) 229-0465. You may also call the DMHC at **1-888-466-2219**.

Accepted Applications for Independent Medical Review

Upon receiving your application for IMR, the DMHC will review your request and notify you whether your case has been accepted. If your case is eligible for IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of UnitedHealthcare, who will make an independent determination of whether or not the care should be provided. The IRO chooses an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor UnitedHealthcare will control the choice of expert reviewers.

UnitedHealthcare must provide the following documents to the IRO within three business days of receiving notice from the DMHC that you have successfully applied for an IMR:

1. The relevant medical records in the possession of UnitedHealthcare or its Network Providers;
2. All information provided to you by UnitedHealthcare and any of its Network Providers concerning UnitedHealthcare and Provider decisions regarding your condition and care (including a copy of UnitedHealthcare's denial notice sent to you);
3. Any materials that you or your Provider submitted to UnitedHealthcare and its Network Providers in support of the request for the health care services;
4. Any other relevant documents or information used by UnitedHealthcare or its Network Providers in determining whether the health care service should have been provided and any statement by UnitedHealthcare or its Network Providers explaining the reasons for the decision. The Plan shall

provide copies of these documents to you and your Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to your health, UnitedHealthcare will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required material to the IRO, UnitedHealthcare will promptly issue you a notification that includes a list of the documents submitted and offer you the opportunity to request copies of those documents from UnitedHealthcare.

If there is any information or evidence you or your Provider wish to submit to the DMHC in support of IMR that was not previously provided to UnitedHealthcare, you may include this information with your application to the DMHC. Also as required, you or your Provider must provide to the DMHC or the IRO copies of any relevant medical records, and any newly developed or discovered relevant medical records after the initial documents are provided, and respond to any requests for additional medical records or other relevant information from the expert reviewers.

Disapproval of a Prior Authorization Request of a Nonformulary Drugs

If a Member objects to a disapproval of a prior authorization request of a “nonformulary” drug and a step therapy exception request, if applicable, through the prior authorization process, s/he, a representative, or the prescribing Provider can file a grievance seeking an external exception review. Information as to how to request a review will be included in the Member’s notice of denial for prior authorization. The Plan will respond to the review within 24 hours of receipt by the Plan of the request, if exigent, and within 72 hours of receipt if non-urgent. The external exception review process is in addition to the right of a member to file a grievance or request for independent medical review administered by the Department.

The Independent Medical Review Decision

The independent review panel will provide its analysis and recommendations on your IMR case in writing, and in layperson’s terms to the maximum extent practical, within 30 calendar days of receiving your request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of an Experimental or Investigational determination, if your Physician determines that the proposed treatment or therapy would be significantly less effective if it did not begin promptly. In this instance, the analysis and recommendations will be rendered within seven calendar days of the request for expedited review. The review period can be extended up to three calendar days for a delay in providing required documents at the request of the expert. The organization shall complete its review and make its determination in writing, and in layperson’s terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director.
- If the disputed health care service or dental services have not been provided and the enrollee’s Provider or the Department certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and provided within three days of the receipt of the information.
- Subject to the approval of the DMHC, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, UnitedHealthcare, you and your Physician with each of the experts’ analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts’ analyses will state

the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by UnitedHealthcare, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the experts' recommendation. In the case of a review of a Disputed Health Care Services or Dental Services denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service or Dental Services are Medically Necessary and cite your medical or dental condition, the relevant documents in the record and the reviewers' relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the health care service or dental services should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the health care service or dental service, UnitedHealthcare will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on UnitedHealthcare. UnitedHealthcare will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, UnitedHealthcare will reimburse either you or your Provider – whichever applies – within five business days. In the case of services not yet rendered to you, UnitedHealthcare will authorize the services within five business days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of your medical condition, and will inform you and your Physician of the authorization.

UnitedHealthcare will promptly reimburse you for reasonable costs associated with Urgently Needed Services or Emergency Health Care Services outside of UnitedHealthcare's Network Provider Network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds your decision to use services outside of UnitedHealthcare's Network Provider Network prior to completing the UnitedHealthcare Grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the Disputed Health Care Services or Dental Services were a Covered Health Care service under the UnitedHealthcare Subscriber contract.

Health care services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under your UnitedHealthcare Health Plan.

For more information regarding the IMR process, or to request an application, please call the Customer Service department.

Complaints Against Network Medical Groups, Providers, Physicians and Hospitals

Claims against a Network Medical Group, the group's Physicians, or Providers,or Hospitals other than claims for benefits under your coverage are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Network Medical Group or one of its Network Providers for claims not involving benefits, UnitedHealthcare agrees to make available the Member appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties except upon agreement between the parties. The Grievance will not be subject to binding arbitration except upon agreement between the parties. Should the parties fail to resolve the Grievance, you or the Network Medical Group or its Network Provider may seek any appropriate legal action deemed necessary. Member claims against UnitedHealthcare will be handled as discussed above under Appealing a Health Care Decision or Requesting a Quality Review.

SECTION 9. GENERAL INFORMATION

- **How to Replace Your Card**
- **Translation Assistance**
- **Speech-and Hearing-Impaired Assistance**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Organ and Tissue Donation**
- **Public Policy Participation**
- **Nondiscrimination Notice**
- **Important Language Information**

This section provides answers to some common and uncommon questions about your coverage. If you have any questions of your own that have not been answered, please call our Customer Service department. If you have special needs, this document may be available in other formats.

What Should I do if I Lose or Misplace My Membership Card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does UnitedHealthcare Offer a Translation Service?

UnitedHealthcare uses a telephone translation service for almost 140 languages and dialects. In addition to Customer Service representatives who are fluent in Spanish, translated Member materials are available upon request. Interpretation services are available at no charge to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. To get help in your language, please call your health plan at UnitedHealthcare of California 1-800-624-8822/ TTY: 711.

Does UnitedHealthcare Offer Hearing-and Speech-Impaired Telephone Lines?

UnitedHealthcare has a dedicated telephone number for the hearing and speech-impaired. This phone number is 711.

How is My Coverage Provided Under Extraordinary Circumstances?

In the event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Network Medical Groups and Hospitals will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Health Care Services. UnitedHealthcare will provide appropriate reimbursement.

Nondiscrimination Notice

UnitedHealthcare does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancenstry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by UnitedHealthcare directly or through a Network Medical Group or any other entity with which UnitedHealthcare arranges to carry out Covered Health Care Services under any of its Health Plans.

This statement is in agreement with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued according to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

If you think you were discriminated against, you may file a grievance with the plan and, if not resolved, you can file a grievance with the Department of Managed Healthcare ("DMHC"). For filing a grievance, please refer to Filing a Grievance under Section 8.

If you think you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can file a complaint with the U.S. Department of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

Important Language Information:

You can get translated written materials and an interpreter at no cost. These rights apply only under California law. These rights shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services.

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your doctor or health plan. To get help in your language, please call your health plan at:

UnitedHealthcare of California 1-800-624-8822 / TTY: 711

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact your health plan at 1-800-624-8822 / TTY: 711.

How Does UnitedHealthcare Compensate Its Network Providers?

UnitedHealthcare itself is not a Provider of health care. UnitedHealthcare typically contracts with independent medical groups to provide medical services to its Members, and with hospitals to provide Hospital Services. Once they are contracted, they become UnitedHealthcare Network Providers.

Network Medical Groups in turn employ or contract with individual Physicians. None of the Network Medical Groups or Network Hospitals, or their Physicians or employees, are employees or agents of UnitedHealthcare. Likewise, neither UnitedHealthcare nor any employee of UnitedHealthcare is an employee or agent of any Network Medical Group, Network Hospital or any other Network Provider.

Most of our Network Medical Groups receive an agreed-upon monthly payment from UnitedHealthcare to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly Premium received by UnitedHealthcare. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Network Medical Group.

Some of UnitedHealthcare's Network Hospitals receive similar monthly payments in return for providing Hospital Services for Members. Other Network Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

At the beginning of each year, UnitedHealthcare and its Network Medical Groups agree on a budget for the cost of services for all UnitedHealthcare Members assigned to the Network Medical Group. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Network Medical Group shares in the savings.

The Network Hospital and Network Medical Group typically participate in programs for Hospital Services similar to what is described above.

Stop-loss insurance protects Network Medical Groups and Network Hospitals from large financial expenses for health care services. UnitedHealthcare provides stop-loss protection to our Network Medical Groups and Network Hospitals that receive the monthly payments described above. If any Network Hospital or Network Medical Group does not obtain stop-loss protection from UnitedHealthcare, it must obtain stop-loss insurance acceptable to UnitedHealthcare.

UnitedHealthcare arranges with additional Providers or their representatives for the provision of Covered Health Care Services that cannot be performed by your assigned Network Medical Group or Network Hospital. Such services include authorized Covered Health Care Services that require a Specialist not available through your Network Medical Group or Network Hospital or Emergency and Urgently Needed Services. UnitedHealthcare or your Network Medical Group pays these Providers at the lesser of the Provider's reasonable charges or agreed-to rates. Your responsibility for Covered Health Care Services received from these Providers is limited to payment of applicable Co-payments/Deductibles. (For more about Co-payments, see **Section 6. Payment Responsibility**.) You may get additional information on UnitedHealthcare's compensation arrangements by contacting UnitedHealthcare or your Network Medical Group.

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants according to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other Providers in our Network through our provider website. Network Physicians and Providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, Out-of-Network Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your Out-of-Network Physician or Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

If you receive a bill for a Covered Health Care Service from a Physician who is not one of our Network Providers, and the service was prior authorized and you have not exceeded any applicable benefit limits, UnitedHealthcare will pay for the service, less the applicable Co-payment/Deductible. (Prior authorization is not required for Emergency Health Care Services and Urgently Needed Services. See Section 3. Emergency Health Care and Urgently Needed Services.) Out-of-Network Providers may not send you a bill for Emergency Health Care Services. You are only required to pay the Co-payment/Deductible amount shown in your Schedule of Benefits. You may also submit a bill to us if an Out-of-Network Provider has refused payment directly from UnitedHealthcare.

If you receive Covered Health Care Services in a Network contracting health care facility but from an Out-of-Network individual health professional, you are only required to pay the Co-payment/Deductible amount specified in your Schedule of Benefits. A Network "contracting health facility" includes, but not limited to, a licensed hospital; ambulatory surgery center or other outpatient setting, lab, radiology or imaging center. You should not be billed more than the amounts shown on your Schedule of Benefits.

How Do I Become an Organ and Tissue Donor?

Transplantation has helped thousands of people suffering from organ failure or in need of corneas, skin, bone or other tissue. The need for donated organs and tissues continues to outpace the supply. At any given time, nearly 50,000 Americans may be waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others.

Almost anyone can be a donor. There is no age limit and the number of donors age 50 or older has increased. If you have questions or concerns about organ donation, speak with your family, doctor or clergy. There are many resources that can provide the information you need to make a responsible decision.

If you do decide to become a donor, be sure to share your decision. Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a Family Member gives consent at the time of your death even if you have signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

How Can I Learn More About Being an Organ and Tissue Donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation (**www.transweb.org**)
- Department of Health and Human Services (**www.organdonor.gov**)

Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then keep the card with you at all times where it can be easily found.

Keep in mind that even if you have signed a donor card, you must tell your family so they can act on your wishes.

How Can I Take Part In in the Establishment of UnitedHealthcare's Public Policy Participation?

UnitedHealthcare gives its Members the opportunity to take part in establishing the public policy of the Health Plan. One-third of UnitedHealthcare of California's Board of Directors is comprised of Health Plan Members. If you are interested in participating in the establishment of the Health Plan's public policy, please call or write our Customer Service department.

SECTION 10. DEFINITIONS

This Section will help you understand the meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Combined Evidence of Coverage and Disclosure Form, as well as the Schedule of Benefits.

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

Adverse Benefit Determination – Means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including the following:

- a determination of a Member's eligibility to take part in the Health Plan (including rescission);
- a determination that services are not covered based on certain exclusions or limitations on otherwise Covered Health Care Services; and
- a determination that benefits are Experimental or Investigational or not Medically Necessary or appropriate.

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

- Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:
- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

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

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

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

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

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

Annual Co-payment Limit – The limit amount of Co-payments a Member is required to pay for certain Covered Health Care Services in a calendar year. (Please refer to your *Schedule of Benefits*.)

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Behavioral Health Treatment for Autism Spectrum Disorder- Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the limit extent practicable, the functioning of a Member with Autism Spectrum Disorder, and meet all of the following criteria:

The treatment is prescribed by a licensed Physician and surgeon of the California Business and Professions Code or developed by a licensed Network psychologist according to the California Business and Professions Code or as authorized under California law.

The treatment is provided under a treatment plan prescribed by a Network Qualified Autism Service Provider and is administered by one of the following:

- A Network Qualified Autism Service Provider.
- A Network Qualified Autism Service Professional supervised and employed by the Network Qualified Autism Service Provider.
- A Network Qualified Autism Service Paraprofessional supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Network Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Network Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the Network Qualified Autism Service Provider does all of the following:

- Describes the Member’s behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member’s progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Autism Spectrum Disorder.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for Network in the treatment program. The treatment plan shall be made available to us upon request.

For a description of coverage of mental health care services for the diagnosis and treatment of Mental Disorders, please refer to **Section 5. Your Medical Benefits** and to the behavioral health supplement to your *Combined Evidence of Coverage and Disclosure Form* for USBHPC.

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can use voluntary control over the functions, and thereby reduce an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such

functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

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

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources in order to promote a quality outcome for the individual Member.

Chronic Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period – A calendar year.

Cognitive Behavioral Therapy – Psychotherapy where the emphasis is on the role of thought patterns in moods and behaviors.

Cognitive Rehabilitation Therapy – Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits due to traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher-level cognitive ability. This therapy is direct, one-on-one, patient contact.

Complementary and Alternative Medicine – Defined by the National Center for Complementary and Alternative Medicine as the broad range of healing philosophies, approaches and therapies that Conventional Medicine does not commonly use, accept, study or make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in hospitals. These types of therapies used alone are often referred to as alternative. When used in combination with other alternative therapies, or in addition to conventional therapies, these therapies are often referred to as complementary.

Completion of Covered Health Care Services – Covered Health Care Services for the Continuity of Care Condition under treatment by the terminated Provider or Out-of-Network Provider will be considered complete, when:

- The Member's Continuity of Care Condition under treatment is medically/clinically stable, and
- There are no clinical contraindications that would prevent a medically/clinically safe transfer to a Network Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the terminated Provider or Out-of-Network Provider, and as applicable, the Member's assigned Network Provider.

Continuity of Care Condition(s) – The Completion of Covered Health Care Services will be provided by: (i) a terminated Provider to a Member who, at the time of the Network Provider's contract termination, was receiving Covered Health Care Services from that Network Provider, or (i) Out-of-Network Provider for newly enrolled Member who, at the time of his or her coverage became effective with UnitedHealthcare, was receiving Covered Health Care Services from the Out-of-Network Provider, for one of the Continuity of Care Conditions, as limited and described below:

1. **An Acute Condition** – A medical condition, including medical and Mental Health, that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Health Care Services will be provided for the duration of the Acute Condition.

   Please refer to Section 5. Your Medical Benefits and to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC for a description of Mental Health

2. **A Serious Chronic Condition** – A medical condition due to disease, illness, or other medical or mental health problem or medical or mental health disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Health Care Services will be provided for the

period of time needed to complete the active course of treatment and to arrange for a clinically safe transfer to a Network Provider, as determined by a UnitedHealthcare Medical Director in consultation with the Member, and either (i) the terminated Provider or (ii) the Out-of-Network Provider and as consistent with good professional practice. Completion of Covered Health Care Services for this condition will not exceed twelve (12) months from the agreement's termination date or 12 months from the effective date of coverage for a newly enrolled Member.

USBHPC will coordinate Continuity of Care for Members requesting continued care with a terminated or Out-of-Network Provider for behavioral health services.

2. **A pregnancy -** A Pregnancy is the three trimesters of Pregnancy and the immediate postpartum period. Diagnosed and documented by (i) the terminated Provider prior to termination of the agreement, or (ii) by the Out-of-Network Provider prior to the newly enrolled Member's effective date of coverage with UnitedHealthcare. Completion of Covered Health Care Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** – An incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Care Services will be provided for the duration of a terminal illness, which may exceed 12 months from the termination date of the provider's agreement or 12 months from the effective date of coverage for a new Member when criteria are met.
5. **The Care of a Newborn** – Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Health Care Services will not exceed twelve (12) months from the: (i) Provider agreement termination date, or (ii) the newly enrolled Member's effective date of coverage with UnitedHealthcare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure –** Performance of a Surgery or Other Procedure that has been authorized by UnitedHealthcare or the Member's assigned Network Provider as part of a documented course of treatment and has been recommended and documented by the: (i) terminating Provider to occur within 180 calendar days of the agreement's termination date, or (ii) Out-of-Network Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with UnitedHealthcare.
7. **Inpatient or institutional care**.

Conventional Medicine – Defined by the National Center for Complementary and Alternative Medicine as medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees. Other terms for Conventional Medicine are allopathic, Western, regular and mainstream medicine.

Co-payments – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Health Care Service. Co-payments may be a specific dollar amount or a percentage of the Allowed Amount, or percentage of the Recognized Amount as applicable, for Covered Health Care Services. Co-payments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

For Co-payments that are specific dollar amount, you are responsible for paying the lesser of the following:

- The Co-payment.
- The negotiated amount, or the Recognized Amount, when applicable.

For Co-payments that are percentage, you are responsible for paying the percentage of the Allowed Amount, or the percentage of Recognized Amount, when appliable.

Covered Health Care Services – Medically Necessary services or supplies provided under the terms of this *Combined Evidence of Coverage and Disclosure Form*, your *Schedule of Benefits* and supplemental benefit materials.

Custodial Care – Care and services that help an individual in the activities of daily living. Examples include: help in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.

Day Treatment Center.- A Network Facility which provides a specific Behavioral Health Treatment Program on a full- or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Network Practitioner and which is also licensed, certified or approved to provide such services by the appropriate state agency.

Deductible – The Deductible is the total of the Allowed Amount or the Recognized Amount when applicable, for certain Covered Health Care Service that you are responsible for paying each Calendar Year before benefits are payable under the *Combined Evidence of Coverage and Disclosure Form*. Please refer to the *Schedule of Benefits* for detailed information on the Deductible amount and Covered Health Care Services subject to the Deductible.

Dependent – A Member of a Subscriber's family who is enrolled with UnitedHealthcare after meeting all of the eligibility requirements of the Subscriber's Employer Group and UnitedHealthcare and for whom applicable Health Plan Premiums have been received by UnitedHealthcare.

Designated Facility – A facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to render Covered Health Care Services for the treatment of specified diseases or conditions. The fact that a hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Virtual Network Provider - A Provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Developmental Delay – Is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and/or social development.

Domestic Partner - A person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is 18 years of age or older. An exception is provided to Subscribers and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
    - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
    - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
    - Is mentally competent to consent to contract.
- Is unmarried or not a Member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Eligible Employee - Is an Eligible Employee who meets the eligibility requirement established by the Employer Group and UnitedHealthcare. (**Please Note:** If you are a Member of a guaranteed association you must abide by the eligibility requirement of the association.)

Emergency Health Care Services – An appropriate medical screening, examination and evaluation by a Physician or other personnel – to the extent provided by law– to determine if an Emergency Medical Condition or Psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Health Care Services include the care, treatment and/or surgery by a Physician necessary to stabilize the patient (regardless of the

department of the hospital in which such further exam or treatment is provided) and relieve or eliminate the Emergency Medical Condition or Psychiatric Emergency Medical Condition within the capabilities of the facility, which includes and Independent Freestanding Emergency Department, and an admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital for the purpose of providing care and treatment necessary to relieve or eliminate a Psychiatric Emergency Medical Condition. For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C. 1395dd(e)(3)),* (For a detailed explanation of Emergency Health Care Services, see **Section 3. Emergency Health Care Services and Urgently Needed Services**.)

Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an Out-of-Network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an inpatient stay or outpatient stay that is connected to the original emergency, unless each of the following conditions are met:

a) The attending emergency physician or treating provider determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
e) Any other conditions as specified by the Secretary.

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

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:

- placing the Member’s health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
    1. there is inadequate time to effect safe transfer to another hospital prior to delivery or
    2. a transfer poses a threat to the health and safety of the Member or unborn child.

An Emergency Medical Condition also includes a Psychiatric Emergency Medical Condition which is a Mental Health Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or others; or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the Mental Health Disorder

Employer Group – Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least fifty percent (50%) of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than one hundred (100) employees, the majority of whom were employed within California, that was not formed primarily for the purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists.

Enteral Feeding – Provision of nutritional requirements through a tube into the stomach or bowel. It may be administered by syringe, gravity, or pump.

ERISA – The Employee Retirement Income Security Act (ERISA) of 1974 is a federal law designated to protect the rights of participants and beneficiaries of employee welfare benefits plans. Please contact your employer's benefit administrator to determine whether your employer is subject to ERISA.

Experimental or Investigational – Defined in **Section 5** under the "Exclusions and Limitations of Benefits" section of this *Combined Evidence of Coverage and Disclosure Form*.

Family Member – The Subscriber's legal spouse or Domestic Partner and any person related to the Subscriber or legal spouse or Domestic Partner by blood, marriage, adoption, assumption of a parent-child relationship or guardianship. An enrolled Family Member is a Family Member who is enrolled with UnitedHealthcare, meets all the eligibility requirements of the Subscriber's Employer Group and UnitedHealthcare, and for whom Premiums have been received by UnitedHealthcare. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and UnitedHealthcare.

Gender Identity Disorder / Gender Dysphoria - A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative.

Group Agreement – The Medical and Hospital Group Subscriber Agreement entered into between UnitedHealthcare and the employer, labor union, trust, organization or association through which you enroll for coverage.

Habilitative Services – Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative and habilitative services under the plan contract.

Health care practitioner - means a physician and surgeon, naturopathic doctor, nurse practitioner, physician assistant, nurse midwife, or a midwife licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code or an initiative act referred to in that division and who is acting within his or her scope of practice.

Health Plan – Your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and supplemental benefit materials.

Health Plan Premiums (or Premiums) – Amounts established by UnitedHealthcare to be paid to UnitedHealthcare by employer on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Health Aide – A person who has completed Home Health Aide training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise help and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home Health Care Visit – Defined as up to two hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four hours of Home Health Aide Services.

Hospice – Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice services.

Hospitalist – A Physician whose sole practice is the management of acutely and/or chronically ill patients' health services in a hospital setting.

Hospital Services – Services and supplies performed or supplied by a licensed hospital on an inpatient or outpatient basis.

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

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

Independent Freestanding Emergency Department - a health care facility that Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and provides Emergency Health Care Services.

Infertility – Either: (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception; or (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Network Provider as a cause of Infertility.

Inpatient Treatment Center - An acute care Network Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Network Practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.

Intellectual Disability – An individual is determined to have intellectual disability based on the following three criteria: Intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less).

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

Late Enrollee – An Eligible Employee or Eligible Employee's Dependent who declined enrollment in the UnitedHealthcare Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability – A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

Limiting Age – The age established by UnitedHealthcare when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage. The Limiting Age is at least 26 years of age as established by federal law.

Long Term Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Manipulative Treatment - The therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medical Detoxification - The medical treatment of withdrawal from alcohol, drug or other substance addiction is covered.

Medically Necessary (or Medical Necessity) - Refers to an intervention, if, as recommended by the treating Physician and determined by the Medical Director of UnitedHealthcare or the Network Medical Group, it is all of the following:

a. A health intervention for the purpose of treating a medical condition;

b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. “Cost-effective” does not necessarily mean lowest price.

A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, if it is Medically Necessary or otherwise required to be covered under the law or otherwise described in Section 5 of this Combined Evidence of Coverage. An intervention may be medically indicated yet not be a covered benefit if it is not Medically Necessary or otherwise required to be covered under the law or otherwise set forth in Section 5 of this Combined Evidence of Coverage.

For Mental Health Care Services and Substance-Related and Addictive Disorders, a service or product addressing the specific needs of the patient, for the purpose of preventing, diagnosis, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

a. In accordance with the generally accepted standards of mental health and substance-related and addictive disorder care.

b. Clinically appropriate in terms of type, frequency, extent, site and duration.

c. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

i. *Treating Physician* means a Physician who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to *treat* (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A *new intervention* is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

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

Medicare Eligible – Those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Member – The Subscriber or any Dependent who is eligible, enrolled and covered by UnitedHealthcare.

Mental Health Disorder – a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Mental Health Care Services - Medically Necessary treatment of a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.* Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* or the *World Health Organization's International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and*

Statistical Manual of Mental Disorders does not mean that treatment for the condition is a Covered Health Care Service.

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

Mental Illness - a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.* Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* or the *World Health Organization's International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Minimum Essential Coverage – Is defined as one of the following:

- Coverage under a specified government program (Medicare, Medicaid, CHIP, Tricare, certain Veterans health)
- Coverage under an eligible employer-sponsored plan (includes COBRA and retiree health)
- Coverage under an individual health plan offered in the individual market within a State;
- Coverage under a grandfathered health plan; or
- Other health benefits coverage that the Secretary of Health and Human Sservices, in coordination with the Secretary of Treasury, recognizes.

Other types of coverage that are not designated by statute or regulation as minimum essential coverage, may be recognized as minimum essential coverage if certain substantive and procedural requirements are met.

Network Hospital – Any general acute care hospital licensed by the State of California that has entered into a written agreement with UnitedHealthcare to provide Hospital Services to UnitedHealthcare's Members. Network Hospitals are independent contractors and are not employees of UnitedHealthcare.

Network Medical Group – An Independent Practice Association (IPA) or medical group of Physicians that has entered into a written agreement with UnitedHealthcare to provide Physician services to UnitedHealthcare's Members. An IPA contracts with independent contractor Physicians who work at different office sites. A medical group employs Physicians who typically all work at one or several physical locations.

Under certain circumstances, UnitedHealthcare may also serve as the Member's Network Medical Group. This includes, but is not limited to, when the Member's PCP contracts directly with UnitedHealthcare and there is no Network Medical Group. Network Medical Groups are independent contractors and are not employees of UnitedHealthcare.

Network Provider – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor who has entered into a written Agreement with the Network of Providers from whom the Member is entitled to receive Covered Health Care Services. Network Providers are independent contractors and are not employees of UnitedHealthcare.

Network Qualified Autism Service Provider – Either of the following:

- A person that is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the person who is nationally certified.

- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the licensee.

For a description of coverage of inpatient and outpatient mental health care services for the diagnosis and treatment of Mental Disorder, please refer to **Section 5. Your Medical Benefits**.

Network Qualified Autism Service Paraprofessional - An unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is supervised by a Network Qualified Autism Service Provider or Network Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Network Qualified Autism Service Provider.
- Meets the education and training qualifications described in Section 54342 Title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a Network Qualified Autism Service Provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

For a description of coverage of inpatient and outpatient mental health care services for the diagnosis and treatment of Mental Disorder, please refer to **Section 5. Your Medical Benefits**.

Network Qualified Autism Service Professional – An individual who meets all of the following criteria:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- Is supervised by a Network Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Network Qualified Autism Service Provider.
- Is a behavioral service Provider who meets the education and experience qualifications described in Section 54342 of Title 17 of California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program.
- Has training and experience in providing services for Autism Spectrum Disorder pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

For a description of coverage of inpatient and outpatient mental health care services for the diagnosis and treatment of Mental Disorder, please refer to **Section 5. Your Medical Benefits**.

Non-Physician Health Care Practitioners - Include but are not limited to: Network Qualified Autism Service Provider, Network Qualified Autism Service Professional, Network Qualified Autism Service Paraprofessional, acupuncturists, optometrists, podiatrists, chiropractors and nurse midwives.

Open Enrollment Period – The time period determined by UnitedHealthcare and the Subscriber's Employer Group when all Eligible Employees and their eligible Family Members may enroll in UnitedHealthcare.

Out-of-Network Mental Health Providers - A psychiatrist, psychologist or other allied behavioral health professional that is licensed, certified or as authorized under California law that has not entered into a written agreement to provide Covered Health Care Services to UnitedHealthcare's Members.

Out-of-Network Providers – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Health Care Services to UnitedHealthcare's Members.

Partial Hospitalization/Day Treatment – A structured ambulatory prgram that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Physician – Any licensed allopathic or osteopathic Physician. It includes a licensed acupuncturist.

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

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

Prevailing Rates – As determined by UnitedHealthcare, the usual, customary and reasonable rates for a particular health care service in the Service Area.

Primary Care Physician (PCP) – A Network Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services. PCPs are independent contractors and are not employees of UnitedHealthcare.

Primary Residence – The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days, or (3) the Member is absent from the residence for more than 100 days in any six-month period.

Primary Workplace – The Facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

Prior Authorization – UnitedHealthcare's review process that decides whether a service is Medically Necessary and not otherwise excluded prior to the Member receiving the service.

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or Skilled Nursing Facility.

Provider – A person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Combined Evidence of Coverage and Disclosure Form* and supplemental benefit materials and as required by state law.

Psychiatric Emergency Medical Condition – A mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

Psychological and Neuropsychological Testing – Psychological and Neuropsychological Testing includes the administration, interpretation, and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Recognized Amount - the amount which Co-payment and applicable Deductible, is based on for the below Covered Health Care Services when provided by Out-of-Network Providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An All Payer Model Agreement if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Regional Organ Procurement Agency – An organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Rehabilitation Services – The individual or combined and coordinated use of medical, physical, occupational and speech therapy for developing or retraining to the limit extent practical the functioning of individuals.

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

Schedule of Benefits – An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Co-payment information.

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

Service Area – A geographic region in the State of California where UnitedHealthcare is authorized by the California Department of Managed Health Care to provide Covered Health Care Services to Members.

Skilled Nursing Care – The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

Skilled Nursing Facility – A comprehensive free-standing rehabilitation Facility or a specially designed unit within a hospital licensed by the State of California to provide Skilled Nursing Care.

Skilled Rehabilitation Care – The care provided directly by a Network Provider or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

Specialist - A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. Specialists are Physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine Specialist, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.

Subacute and Transitional Care – Care provided to a Member as an inpatient of a Skilled Nursing Facility that is more intensive licensed Skilled Nursing Care than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

Subscriber – The individual enrolled in the Health Plan for whom the appropriate Health Plan Premiums have been received by UnitedHealthcare and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Substance-Related and Addictive Disorder Services - Medically Necessary treatment of a substance-related and addictive disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.* Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* or the *World Health Organization's International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Telehealth – The mode of delivering Covered Health Care Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care Provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care Provider who provides Covered Health Care Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Health Care Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care Provider located at a distant site.

Telemedicine – The use of interactive audio, video or other electronic media to deliver health care. This includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education and Remote Physiologic Monitoring. This term does not include services performed using a telephone or facsimile machine.

Totally Disabled or Total Disability – For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an injury or illness. Determination of Total Disability will be made

by a Network Medical Group Physician on the basis of a medical examination of the Member and upon concurrence by UnitedHealthcare's Medical Director.

Transitional Residential Recovery Services - Substance-Related and Addictive Disorder or chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

Urgently Needed Services – Covered Health Care Services that are provided when the Member's Network Medical Group is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the geographic area served by their Network Medical Group. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Usual and Customary Charges (U&C) - Means charges for medical services or supplies for which UnitedHealthcare is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

Utilization Review Committee – A committee used by UnitedHealthcare or a Network Medical Group to promote the efficient use of resources and maintain the quality of health care. If necessary, this committee will review and determine whether particular services are Covered Health Care Services.

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation; when necessary, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* PROVIDES A DESCRIPTION OF THE BENEFITS AVAILABLE TO YOU UNDER YOUR UNITEDHEALTHCARE HEALTH PLAN. THE AGREEMENT BETWEEN UNITEDHEALTHCARE AND YOUR EMPLOYER CONTAINS ADDITIONAL TERMS SUCH AS PREMIUMS, LENGTH OF CONTRACT, AND GROUP TERMINATION. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT UNITEDHEALTHCARE AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com

PCA881995-000

Effective 1/1/23

Travel and Lodging Program Rider
UnitedHealthcare of California

This Rider to the *Combined Evidence of Coverage and Disclosure Form (Certificate)* provides a Member with a travel and lodging allowance related to the Covered Health Care Service provided by a Network provider that is not available in the Member's state of residence due to law or regulation when such services are received in another state, as legally permissible.

Because this Rider is part of a legal document (the Group Agreement), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 10: Definitions.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of California. When we use the words "you" and "your," we are referring to people who are Members, as that term is defined in *Section 9: Defined Terms.*

Travel and Lodging Program

The *Travel and Lodging Program* provides support for the Member under the Agreement as described above. The program provides an allowance for reasonable travel and lodging expenses for a Member and travel companion when the Member must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Care Service.

This program provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Member. An allowance of up to $2,000 per Member per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Care Service. Lodging expenses are further limited to $50 per night for the Member, or $100 per night for the Member with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding the *Travel and Lodging Program*, you may contact us at **www.myuhc.com** or the telephone number on your identification (ID) card.

_____

(Name and Title)

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

PCA874401-000

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ATTACHMENT D
SMALL EMPLOYER GROUP
ELIGIBILITY CRITERIA

UnitedHealthcare may terminate or refuse to reinstate the Agreement with Group pursuant to Section 7.02.04 of the Agreement if Group fails at any time to meet all of the following requirements:

1. **Date of Determination** – The Enrolling Group must meet the definition of a small employer under Health and Safety Code §1357.500. The size of the Enrolling Group shall be determined on the anniversary of the effective date of the Agreement.

   For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, a small employer is any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least fifty percent (50%) of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than fifty (50) eligible employees, the majority of whom were employed within California, that was not formed primarily for purposes of buying health benefit plans, and in which bona fide employer-employee relationship exists.

2. **Minimum Enrolling Group Contribution** – Enrolling Group must contribute at least fifty percent (50%) of the average Premium for all Subscribers.

3. **Eligible Person Participation** Requirements--

   - *For all Small Employers:* There must be a minimum of one Eligible Person with at least one active Eligible Person enrolled in the health plan.

   - *Enrolling Groups Offering UnitedHealthcare Plans:*

     - If contributory, a minimum of 25% of Eligible Persons must enroll (excluding COBRA participants) with UnitedHealthcare or affiliated companies. Eligible Persons who waive coverage due to group coverage through another employer are excluded from this calculation.

     - If non-contributory, 100% of Eligible Persons must enroll. Eligible Persons who waive coverage due to group coverage through another employer are excluded from this calculation.

4. **For Groups Offering UnitedHealthcare and a Staff Model**

   - There must be at least 75% participation between the two carriers with a minimum of 5 Eligible Persons enrolling in UnitedHealthcare plans.
   - If non-contributory, 100% of Eligible Persons must enroll. Eligible Persons who waive coverage due to group coverage through another employer are excluded from this calculation.

5. **Exclusivity.** For the purposes of this Attachment D, the exclusivity requirements are applicable whether it is UnitedHealthcare of California and/or UnitedHealthcare Insurance Company.

6. **Active Employees.** There must be a minimum of one Eligible Person with at least one active Eligible Person enrolled in the health plan.

CALIFORNIA

UnitedHealthcare®

Mental Health and Substance-Related and Addictive Disorder Services Provided by U.S. Behavioral Health Plan, California

Supplement to the Combined Evidence of Coverage and Disclosure Form

TABLE OF CONTENTS

INTRODUCTION

WELCOME TO U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA

THIS IS A SUPPLEMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA MEDICAL *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM*

Note: U.S. Behavioral Health Plan, California is the formal legal name of the entity providing your Behavioral Health Care benefits. It operates using the brand name OptumHealth Behavioral Solutions of California. If you see documents labeled or referencing OptumHealth Behavioral Solutions of California, those refer to U.S. Behavioral Health Plan, California.

Your UnitedHealthcare of California Medical Plan includes Mental Disorder and Substance-Related and Addictive Disorder coverage through U.S. Behavioral Health Plan, California (USBHPC). This coverage includes the treatment of Severe Mental Illness (SMI) for persons of any age and treatment for children under the age of 18 with Serious Emotional Disturbance (SED). As a USBHPC Member, you and your eligible Dependent always have direct, around-the-clock access to behavioral health benefits. You do not need to go through a Primary Care Physician (PCP) to access your behavioral health benefits, and all services are completely confidential.

This *Combined Evidence of Coverage and Disclosure Form* will help you become more familiar with your Behavioral Health Care benefits. This *Combined Evidence of Coverage and Disclosure Form* should be used in conjunction with your *UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your Behavioral Health Plan and should answers many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 7. Definitions.**

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership, and it should be read completely and carefully. All applicants have a right to view this document prior to enrollment. Individuals with special behavioral health needs should carefully read those sections that apply to them.

What else should I read to understand my benefits?

Along with this Combined Evidence of Coverage and Disclosure Form, be sure to review your USBHPC Schedule of Benefits in this Combined Evidence of Coverage and Disclosure Form and your UnitedHealthcare of California Medical Schedule of Benefits for details of your particular Behavioral Health Plan, including any Copayments or coinsurance that you may have to pay when accessing Behavioral Health Services. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at 1-800-999-9585, or for the hearing and speech impaired dial 711 and at the operator's request, say or enter "1-800-999-9585.

You may write to USBHPC at the following address:

U.S. Behavioral Health Plan, California
P. O. Box 2839
San Francisco, CA 94126
Or visit USBHPC's Web site:
www.liveandworkwell.com

SECTION 1. UNDERSTANDING BEHAVIORAL HEALTH: YOUR BENEFITS

- **What are Behavioral Health Services?**
- **What is a Mental Disorder?**
- **What is a Severe Mental Illness?**
- **What is the Serious Emotional Disturbance of a Child?**
- **What does USBHPC do?**

This Section helps you understand what behavioral health services are and provides a general understanding of some of the services U.S. Behavioral Health Plan, California (USBHPC) provides.

What are Behavioral Health Services?

Behavioral Health Services are those services provided or arranged by USBHPC for the Medically Necessary treatment of:

- Mental Disorders, including but not limited to treatment for the Severe Mental Illness of an adult or child and/or the Serious Emotional Disturbance of a Child, and/or
- Alcohol and drug problems, also known as Substance-Related and Addictive Disorder, substance use, substance abuse or chemical dependency.

What is a Mental Disorder?

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Any mental health condition identified as a Mental Disorder in the DSM IV is covered. USBHPC does not cover services for conditions that the DSM IV identifies as something other than a “mental disorder” such as relational problems, e.g. couples counseling or family counseling.

Mental Disorders also include a Severe Mental Illness of a Person of Any Age (“Severe Mental Illness” or “SMI”) or a Serious Emotional Disturbance of a Child under the Age of 18 (“Serious Emotional Disturbance of a Child” or “SED”) as defined in the most recent edition of the *DSM*.

What is a Severe Mental Illness?

A Severe Mental Illness (SMI) of a person of any age means the following Mental Disorders:

- Anorexia Nervosa
- Bipolar Disorder (manic-depressive illness)
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or autism, including Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

What is a Serious Emotional Disturbance of a Child?

A Serious Emotional Disturbance (SED) of a Child under age 18 means a condition identified as a Mental Disorder in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), other than a primary substance-

related and addictive disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

a. As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and (2) either

   i. the child is at risk of removal from home or has already been removed from the home; or

   ii. the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

b. The child displays psychotic features, risk of suicide or violence due to a Mental Disorder; or

c. The child meets the special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

What does U.S. Behavioral Health Plan, California do?

USBHPC arranges for the provision of Behavioral Health Services to our Members.

- You have direct 24-hour phone access to our services.
- Your Medically Necessary Behavioral Health Services are coordinated and paid for as provided under your Behavioral Health Plan, so long as you use USBHPC Participating Providers.
- You may be responsible for payment of some Copayments or Coinsurance amounts, as set forth in the attached *Schedule of Benefits*.

All services covered under this Behavioral Health Plan will be provided by a USBHPC Participating Provider except in the case of an Emergency. Pre-Authorization is required for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through USBHPC for Inpatient services, Residential Treatment services, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment and Psychological Testing when necessary to diagnose and evaluate a Mental Disorder , except in the event of an Emergency. If you have questions about your benefits, simply call the USBHPC Customer Service Department at 1-800-999-9585 at any time. Our staff is always there to assist you 24 hours a day, with understanding your benefits, authorizing services, helping you select a Provider, or anything else related to your USBHPC Behavioral Health Plan.

Your USBHPC Behavioral Health Plan provides coverage for the Medically Necessary treatment of Mental Disorders and Substance-Related and Addictive Disorder on both an inpatient and outpatient basis. Details concerning your behavioral health benefits can be found in your *Schedule of Benefits* and in **Section 4** of this *Combined Evidence of Coverage and Disclosure Form*.

SECTION 2. GETTING STARTED: YOUR PARTICIPATING PROVIDER

- **Do I need a referral?**
- **How do I access Behavioral Health Services?**
- **Choice of Physicians and Providers**
- **Continuity of Care**

This Section explains how to obtain USBHPC Behavioral Health Services and the role of USBHPC's Participating Providers.

Do I need a referral from my Primary Care Physician to get Behavioral Health Services?

No. You can visit the USBHPC Website at www.liveandworkwell.com to find a Participating Provider or call USBHPC directly to obtain Behavioral Health Services. If you would like us to, we will help coordinate the care you receive from your USBHPC Participating Provider and the services provided by your Primary Care Physician (PCP). This may be very important when you have both medical and behavioral health conditions. USBHPC will obtain the appropriate consents before information is released to your PCP. You may call USBHPC Customer Service at any time to start this process.

How do I access Behavioral Health Services?

Step 1

To access Behavioral Health Services, you should contact USBHPC first, except in an Emergency. You may either visit USBHPC's Website at www.liveandworkwell.com to find a Participating Provider or call USBHPC Customer Service at 1-800-999-9585. When you call USBHPC Customer Service, a USBHPC staff member will make sure you are an eligible Member of the USBHPC Behavioral Health Plan and answer any questions you may have about your benefits. The USBHPC staff member will conduct a brief telephone screening by asking you questions, such as:

- What are the problems or symptoms you are having?
- Are you already seeing a Provider?
- What kind of Provider do you prefer?

You will then be given the name and telephone number of one or more USBHPC Participating Providers near your home or work that meets your needs.

Step 2

You call the USBHPC Participating Provider's office to make an appointment. If your request for services is non-urgent, the Participating provider is expected to offer you an appointment within ten (10) working days

Step 3

You do not need prior approval for routine outpatient services. However, all inpatient services and residential treatment services must be pre-authorized. Also certain non-routine outpatient services that you receive from your USBHPC Participating Provider may need pre-authorization from USBHPC, except in the event of an Emergency. Non-routine outpatient services are: Intensive Outpatient Program Treatment; Outpatient Electro-Convulsive Treatment; Outpatient Treatment extended beyond 45 minutes; Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs; Medical Detoxification; Methadone Maintenance Treatment; and Psychological Testing when necessary to diagnose and evaluate a Mental Disorder, except in the event of an Emergency. After your first Visit, your USBHPC Participating Provider will get any necessary approval from USBHPC before you receive these services. Such services must be provided at the office of the Participating Practitioner or at a participating Outpatient Treatment Center.

Choice of Physicians and Providers

USBHPC's Participating Providers include hospitals, group practices and licensed behavioral health professionals, which include psychiatrists, psychologists, social workers, marriage and family therapists, and nurse practitioners. All Participating Providers are carefully screened and must meet strict USBHPC licensing and program standards.

Call the USBHPC Customer Service Department for:

- Information on USBHPC Participating Providers,
- Provider office hours,
- Background information such as their areas of specialization,
- A copy of our *Provider Directory*.

Facilities

Along with listing our Participating Providers, your USBHPC Participating Provider Directory has detailed information about our Participating Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Providers. If you need a copy or would like assistance picking you Participating Provider, please call our Customer Service Department. You can also find an online version of the USBHPC Participating Provider Directory at **www.liveandworkwell.com**.

What if I want to change my Participating Provider?

Simply call the USBHPC Customer Service toll-free number at 1-800-999-9585 to select another USBHPC Participating Provider.

If I see a Provider who is not part of USBHPC's Provider Network, will it cost me more?

Yes. If you are enrolled in this USBHPC Behavioral Health Plan and choose to see a Provider who is not part of the USBHPC network, the services will be excluded; and you will have to pay for the entire cost of the treatment (except in an Emergency) with no reimbursement from USBHPC.

Can I call USBHPC in the evening or on weekends?

Yes. If you need services after normal business hours, please call USBHPC's Customer Service Department at 1-800-999-9585. For the hearing and speech impaired, dial 711 and at the operator's request, enter "1-800-999-9585.

A staff member is always there to help.

Continuity of Care with a Terminated Provider

In the event your Participating Provider is no longer a part of the USBHPC Provider network for reasons other than breach of contract, a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from that Provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same terminated Provider.

For a Member to continue receiving care from a terminated Provider, the following conditions must be met:

1. Continuity of Care services from a terminated Provider must be preauthorized by USBHPC;
2. The requested treatment must be a Covered Service under this Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;

4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by USBHPC for current Participating Providers providing similar services who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Services for the Continuity of Care Condition under treatment by the Terminated or Non-Participating Mental Health Provider will be considered complete when:

i. the Member's Continuity of Care Condition under treatment is medically stable, and

ii. there are no clinical contraindications that would prevent a medically safe transfer to a Participating Mental Health Provider as determined by a USBHPC Medical Director (or designee) in consultation with the Member, the Terminated Mental Health Provider and, as applicable, the Member's receiving Participating Provider.

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 7. Definitions**, and believe you qualify for continued care with the terminating Provider, please call the Customer Service Department and request the form "Request for Continuity of Care." Complete and return the form to USBHPC as soon as possible, but within thirty (30) calendar days of the Provider effective date of termination.

If you have any questions about this provision or would like a copy of our Continuity of Care Policy, you may call our Customer Service Department.

Continuity of Care for New Members

Under certain circumstances, new Members of USBHPC may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance may be available for a new Member who:

1. Did not have the option to continue with his/her previous behavioral health plan at time of enrollment;
2. Had no other behavioral health plan choice other than through USBHPC;
3. Is under treatment by a Non-Participating Provider at the time of enrollment for an acute or serious chronic mental health condition;
4. Is receiving treatment that is a benefit under this USBHPC Benefit Plan; and
5. Was not offered a plan with an out-of-network option.
6. The Member must be new to USBHPC as a result of the Members' Employer Group changing health plans;

Behavioral Health Services provided by a Non-Participating Provider may be covered by USBHPC for the purpose of safely transitioning you or your Dependent to a USBHPC Participating Provider. If the Behavioral Health Services are preauthorized by USBHPC, USBHPC may cover such services to the extent they would be covered if provided by a USBHPC Participating Provider under the USBHPC Behavioral Health Plan. This means that you will only be responsible for your Copayment or coinsurance listed on the *Schedule of Benefits*. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon USBHPC Participating Providers, including reimbursement methodologies and rates of payment.

These Continuity of Care services, except for Emergency Services, must be approved by USBHPC. If you would like to request continuing treatment from a Non-Participating Provider, call the USBHPC Customer Service Department within 30 days. If you have any questions or would like a copy of USBHPC's continuity-of-care policy, call or write the USBHPC Customer Service Department.

Outpatient Treatment

For outpatient treatment, USBHPC will authorize an appropriate number of Visits for you to continue treatment with the existing Non-Participating Provider in order to transition you safely to a USBHPC Participating Provider.

SECTION 3. EMERGENCY SERVICES AND URGENTLY NEEDED SERVICES

- **What is an Emergency?**
- **What are Psychiatric Emergency Services?**
- **What To Do When You Require Psychiatric Emergency Services**
- **What To Do When You Require Urgently Needed Services**
- **Continuing or Follow-Up of Emergency Treatment**
- **If I am out of State or traveling, am I still covered?**

Worldwide, wherever you are, USBHPC provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

If you believe you are experiencing an Emergency condition, call 911 or go directly to the nearest hospital emergency room or other facility for treatment.

What is an Emergency?

An Emergency is defined as a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected by the Member to result in any of the following:

- Immediate harm to self or others;
- Placing your health in serious jeopardy;
- Serious impairment of your functioning; or
- Serious dysfunction of any bodily organ or part.

A situation will be considered an Emergency if you or your Dependent are experiencing a situation which, absent immediate medical attention, could reasonably be expected to result in serious deterioration to your mental health.

An Emergency Medical Condition also includes a Psychiatric Emergency Medical Condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

a. an immediate danger to himself or herself or others; or
b. immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

What are Psychiatric Emergency Services?

Psychiatric Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 Emergency response system. It also includes the medical screening, examination and evaluation by a Physician, or other licensed personnel – to the extent provided by law – to determine if a Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment by a Physician necessary to stabilize or eliminate the Emergency condition within the capabilities of the facility which includes admission or transfer to a psychiatric unit within a general acute hospital or acute psychiatric hospital for the purpose of providing care and treatment necessary to relieve or eliminate Psychiatric Emergency Medical Condition, if in the opinion of the treating provider it would not result in material deterioration of the Member's condition.

What To Do When You Require Psychiatric Emergency Services

Step 1: In an Emergency, get help or treatment immediately.

This means you should call 911 or go directly to the nearest medical facility for treatment.

Step 2: Then, within 48 hours of your Emergency, or as soon as is reasonably possible after your condition is stable, you, or someone acting on your behalf, must call USBHPC at 1-800-999-9585.

This is important.

Psychiatric Emergency Services are covered only as long as the condition continues to be an Emergency. Once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the Emergency care facility will not be covered.

Step 3: USBHPC will arrange follow up services for your condition after an Emergency. USBHPC may move you to a Participating Provider in our network, as long as the move would not harm your health.

It is appropriate for you to use the 911 Emergency response system, or alternative Emergency system in your area, for assistance in an Emergency situation when ambulance transport services are required and you reasonably believe that your condition is immediate, serious and requires Emergency transport services to take you to the appropriate facility.

What To Do When You Require Urgently Needed Services

In-Area Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Provider, you should contact your Participating Provider. If you are calling during non-business hours, and your Participating Provider is not immediately available, call USBHPC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or USBHPC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

Out-of-Area Urgently Needed Services

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member's Participating Provider and the Member experiences a mental condition that, while less serious than an Emergency, could result in the serious deterioration of the Member's mental health if not treated before the Member returns to the geographic area serviced by his or her Participating Provider.

When you are temporarily outside the geographic area served by your Participating Provider, and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Participating Provider. If you are calling during nonbusiness hours, and your Provider is not immediately available, call USBHPC Customer Service Department for assistance in finding a Provider near your area. If your Participating Provider or USBHPC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

You, or someone else on your behalf, must notify USBHPC or your Participating Provider within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services.

It is very important that you follow the steps outlined above. If you do not, you may be financially responsible for services received.

Continuing or Follow-up of Emergency Treatment or Urgently Needed Services

If you require Behavioral Health Services following an Emergency or Urgently Needed Services and you desire that these services be covered, the Behavioral Health Services must be coordinated and authorized by USBHPC. In addition, if a transfer does not create an unreasonable risk to your health, USBHPC may require that you transfer to a USBHPC Participating Provider designated by USBHPC for any treatment following the Emergency or Urgently Needed Services.

Failure to transfer or to obtain approval from USBHPC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the Emergency or Urgently Needed Services criteria outlined in this document.

If I am out of State or traveling, am I still covered?

Yes, but only in an Emergency or Urgent situation. If you think you are experiencing an Emergency or require Urgently Needed Services, get treatment immediately. Then, as soon as reasonably possible, call USBHPC Customer Service Department to ensure your Emergency Treatment or Urgently Needed Services are covered. **This is important**.

If you are traveling outside of the United States, you can reach USBHPC by calling 1-877-447-5915 for additional instructions on what to do in the case of an Emergency or Urgent situation.

Note: Under certain circumstances, you may need to pay for your Emergency or Urgently Needed Services at the time of treatment. If this is necessary, please pay for such services and then contact USBHPC at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to USBHPC, please refer to **Section 5. Overseeing Your Behavioral Health Services** in this *Combined Evidence of Coverage and Disclosure Form.*

SECTION 4. COVERED BEHAVIORAL HEALTH SERVICES

- **What Behavioral Health Services are covered?**
- **Exclusions and Limitations**

This section explains your Behavioral Health Benefits, including what is and is not covered by USBHPC. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you need to refer to your Schedule of Benefits, a copy of which is included with this document.

What Behavioral Health Services are covered?

Behavioral Health Services are covered only when they are:

- Incurred while the Member is eligible for coverage under this Behavioral Health Plan;
- Medically Necessary;
- Pre-Authorized for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through USBHPC for Inpatient services, Residential Treatment services, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment and Psychological Testing, except in the event of an Emergency; and
- Rendered by a USBHPC Participating Provider, except in the case of an Emergency.
- Any mental health condition identified as a "mental disorder" in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. USBHPC does not cover services for conditions that the DSM IV identifies as something other than a “mental disorder” such as relational problems, e.g. couples counseling or family counseling. Mental Disorders also include a Severe Mental Illness of Person of Any Age (“SMI”) or a Serious Emotional Disturbance of a Child under the Age of 18 (“SED”), as identified in the most recent edition of the DSM.

USBHPC will pay for the following Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or Substance-Related and Addictive Disorder as outlined in the *Schedule of Benefits*, provided the above criteria have been satisfied. You should refer to your *Schedule of Benefits* for further information about your particular Behavioral Health Plan.

I. Mental Health Services for the diagnosis and treatment of Mental Disorders including SMI and SED conditions, and Medically Necessary Behavioral Health Treatment administered by qualified autism service providers who are either licensed providers under the Business and Professions Code acting within the scope of their license or other health professionals as authorized under California law or persons, entities or groups certified by a national entity, qualified autism professionals and paraprofessionals that are employed and supervised by a qualified autism service provider who may provide Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or autism as medically necessary:

A. **Inpatient**

1. **Inpatient Mental Health Services –** psychiatric inpatient services**,** including room and board, drugs and services, including psychiatric inpatient services from licensed mental health providers including but not limited to psychiatrists and psychologists, provided at an Inpatient Treatment Center, Residential Treatment Center are covered when Medically Necessary, preauthorized by USBHPC, and provided at a Participating Facility.
2. **Inpatient Physician Services** – Medically Necessary inpatient psychiatric services, including voluntary psychiatric inpatient services provided by a Participating Practitioner acting within the scope of their license

while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Residential Treatment Center and which have been preauthorized by USBHPC.

B. **Outpatient**

1. **Outpatient Mental Health Services** – Medically Necessary Mental Health Services provided by a Participating Practitioner including individual and group mental health evaluation and treatment and services for the purpose of monitoring drug therapy. Certain outpatient services that require preauthorization by USBHPC, when Medically Necessary are Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment; Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs; and Psychological Testing when necessary to diagnose and evaluate a Mental Disorder and authorized. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center. Intensive Psychiatric Treatment Programs may include Partial Hospitalization/ Day Treatment Programs and Intensive Outpatient Treatment as intensive outpatient care.

2. **Behavioral Health Treatment for Pervasive Developmental Disorder ("PDD") or Autism** – Preauthorization required for Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or autism, and that meet the criteria required by California law. Please refer to **Section 7, Definitions**, for a description of the required criteria.

3. **Intensive Psychiatric Treatment Programs –** when provided at a Participating Facility or Day Treatment Center, preauthorization is required. These programs include:

- Short-term hospital-based intensive outpatient care (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

II. Substance-Related and Addictive Disorder Services

A. **Inpatient**

1. **Inpatient Substance-Related and Addictive Disorder Services, including Medical Detoxification provided at an Inpatient Treatment Center** – Medically Necessary Substance-Related and Addictive Disorder Services, including Medical Detoxification, which have been preauthorized by USBHPC and are provided by a Participating Practitioner while the Member is confined in a Participating Inpatient Treatment Center or at a Participating Residential Treatment Center

2. **Inpatient Physician Care** – Medically Necessary Substance-Related and Addictive Disorder Services, including Medical Detoxification, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been preauthorized by USBHPC.

3. **Medical Detoxification** – Medical Detoxification services, including room and board, drugs, dependency recovery services, education and counseling are covered when provided by a Participating Practitioner at a Participating Inpatient Treatment Center or at a Residential Treatment Center when preauthorized by USBHPC.

4. **Substance-Related and Addictive Disorder Services including Transitional Residential Recovery Services Rendered at a Residential Treatment Center** – Medically Necessary Substance-Related and Addictive Disorder Services, provided to a Member during confinement at a Participating Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and preauthorized by USBHPC.

B. **Outpatient**

1. **Outpatient Substance-Related and Addictive Disorder Services -** Medically Necessary Substance-Related and Addictive Disorder services provided by a Participating Practitioner at a Participating Outpatient or Day Treatment Center and preauthorized, or at the office of a Participating Practitioner including Outpatient Evaluation and Treatment for Chemical Dependency:

   - day treatment programs including partial hospitalization
   - intensive outpatient programs
   - individual and group chemical dependency counseling, and
   - Medication treatment and withdrawal.

2. **Outpatient Physician Care** – Medically Necessary Substance-Related and Addictive Disorder Services provided by a Participating Practitioner, and preauthorized by USBHPC, e.g. Intensive Outpatient Program Treatment, Partial Hospitalization/ Day Treatment and Outpatient Treatment extending beyond 45 minutes. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient or Day Treatment Center.

3. **Methadone Maintenance Treatment** - Medically Necessary methadone maintenance treatment is covered when, preauthorized by USBHPC and provided at facilities licensed to provide such treatment.

III. Other Behavioral Health Services

1. **Ambulance** – Use of an ambulance (land or air) for Emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 Emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services.

   Use of an ambulance or a psychiatric transport service for a non-Emergency is covered only when specifically authorized by USBHPC and if:

   - USBHPC or a Participating Practitioner determines the Member's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and
   - The use of other means of transportation would endanger the Member's health.
   - These services are covered only when the vehicle transports the Member to or from covered Behavioral Health Services.

2. **Laboratory Services** – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Disorder and/or Substance-Related and Addictive Disorder**.**

3. **Inpatient Prescription Drugs** – Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder or Substance-Related and Addictive Disorder while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Substance-Related and Addictive Disorder a Residential Treatment Center.

4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder.

5. **Psychological and Neuropsychological Testing** – Medically Necessary psychological testing is covered when authorized by USBHPC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests. Neuropsychological Testing does not require prior authorization unless required by the benefit plan.

Exclusions and Limitations

Unless described as a Covered Service in **Section 4. Covered Behavioral Health Services** of this behavioral health supplement and **Section 5. Your Covered Benefits** in the *Combined Evidence of Coverage and Disclosure Form*, the following services and benefits described below are excluded from coverage under this Behavioral Health Plan. Also, please see Exclusions and Limitations of the *Combined Evidence of Coverage and Disclosure Form* as to any additional exclusions and limitations relating to behavioral health services.

1. Any Inpatient confinement, treatment, service or supply not authorized by USBHPC, except in the event of an Emergency.
2. The following Outpatient treatments require preauthorization by USBHPC, except in the event of an Emergency: Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment; Behavioral health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs: Medical Detoxification; Methadone Maintenance Treatment, and Psychological Testing. These services are excluded when not preauthorized and not provided in the event of an Emergency.
3. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by USBHPC.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable workers' compensation laws are not covered.
6. Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this behavioral health plan is expressly required by federal or state law.
7. Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or Autism must have a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated and is discontinued when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.
8. Treatments which do not meet national standards for mental health professional practice.
9. Routine custodial and convalescent care.
10. Any services provided by non-licensed Providers other than services provided to those Members diagnosed with PDD or autism that may be provided by a QAS provider, QAS professional or QAS paraprofessional as defined in the definitions section of this Evidence of Coverage.
11. Pastoral or spiritual counseling.
12. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.
13. School counseling and support services, household management training, peer-support services, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability.
14. Genetic counseling services.
15. Community care facilities that provide 24-hour nonmedical residential care except when medically necessary.
16. Weight control programs and treatment for addictions to tobacco, nicotine or food.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a *DSM* diagnosis.

18. Personal or comfort items, and non-Medically Necessary private room and/or private-duty nursing during inpatient hospitalization are not covered.

19. With the exception of injectable psychotropic medication as set forth in **Section 4**, all nonprescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Nonprescription and prescription drugs prescribed by a USBHPC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and nonprescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner are covered under the inpatient benefit.)

20. Surgery.

21. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.

22. Treatment sessions by telephone or computer Internet services (instant messaging, chat rooms, etc.). **Exception:** Telehealth technology may be utilized in rural geographic areas where other appropriate treatment settings for PDD and/or autism are not available and/or for supervision of treatment sessions for PDD and/or autism.

23. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations or career counseling.

24. Educational Services for Developmental Delays and Learning Disabilities. Educational Services for Developmental Delays and Learning Disabilities are not health care services and are not covered. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade are not covered. The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress: academic coaching, teaching members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

    USBHPC refers to the *American Academy of Pediatrics, Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services.

    For example, USBHPC does not cover:

    - Items and services that increase academic knowledge or skills;
    - Special education (teaching to meet the educational needs of a person with intellectual disability, Learning Disability, or Developmental Delay.) (A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to covered services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified healthcare professional, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law.
    - Teaching and support services to increase academic performance;
    - Academic coaching or tutoring for skills such as grammar, math, and time management;
    - Speech training that is not Medically Necessary, and not part of an approved treatment plan and not provided by or under the direct supervision of a Participating Provider acting within the scope of his or her license under California law that is intended to address speech impediments;
    - Teaching how to read, whether or not member has dyslexia;
    - Educational testing;
    - Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a

Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply or exclude medically necessary behavior health therapy services for treatment of pervasive developmental disorders (PDD) or Autism.

25. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.
26. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the USBHPC Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form,* procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met:

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy.)
- The source of information to be relied upon by USBHPC in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include, but are not limited to the following:
  - The Member's Medical records;
  - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
  - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
  - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
  - Expert medical opinion;
  - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
  - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);

– USBHPC Technology Assessment Committee Guidelines.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external independent review of USBHPC's coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies."

27. Services provided to the Member on an Out-of-Network basis other than if authorized by the Plan.
28. Services rendered by a Non-Participating Provider are not covered, except for Emergency Services or services authorized by USBHPC.
29. Services rendered outside the Service Area are not covered, except for Emergency Services or Urgently Needed Services.
30. Services following discharge after receipt of Emergency Services or Urgently Needed Services are not covered without a Participating Provider's or USBHPC's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from a Participating Provider will not entitle the Member to coverage.

SECTION 5. OVERSEEING YOUR BEHAVIORAL HEALTH SERVICES

- **How USBHPC Makes Important Benefit Decisions**
- **Second Opinions**
- **New Treatment and Technologies**
- **Experimental and Investigational Therapies**
- **Appealing a Behavioral Health Benefit Decision**
- **Independent Medical Review**

This section explains how USBHPC authorizes or makes changes to your Behavioral Health Services, how we evaluate new behavioral health technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your Behavioral Health Plan, including how to appeal a behavioral health benefit decision by USBHPC or one of our Participating Providers. You will learn the process that is available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How USBHPC Makes Important Benefit Decisions

Authorization, Modification and Denial of Behavioral Health Services

When a Member requests Mental Health Services or Substance-Related and Addictive Disorder Services, USBHPC uses established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating Mental Health Services are based on empirical research and industry standards. These are the *MCAP Behavioral Health Criteria*. For Substance-Related and Addictive Disorder Services USBHPC uses the *American Society of Addiction Medicine Placement Guidelines for Substance Related Disorder – Version II-Revised*. The UM criteria used to deny, delay or modify requested services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guideline, based on a particular diagnosis, upon request.

If you or your Dependent(s) are receiving Behavioral Health Services from a school district or a regional center, USBHPC will coordinate with the school district or regional center to provide Case Management of your Behavioral Health Treatment Program. Upon USBHPC's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

The USBHPC qualified Physician or other appropriate qualified licensed health care professional, and its Participating Providers make decisions to approve, deny, delay or modify requests for authorization of Behavioral Health Services, based on Medical Necessity, within the following time frames as required by California state law:

- Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from USBHPC's receipt of information reasonably necessary to make the decision.
- If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the decision would be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after USBHPC's receipt of the information reasonably necessary and requested by USBHPC to make the determination.

If the decision cannot be made within these time frames because (i) USBHPC is not in receipt of all the information reasonably necessary and requested, or (ii) USBHPC requires consultation by an expert reviewer, or (iii) USBHPC has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, USBHPC will notify the Participating Provider and the Member, in writing, that a

decision cannot be made within the required time frame. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by USBHPC, then USBHPC shall approve or deny the request for authorization within the time frame specified above as applicable.

USBHPC notifies requesting Participating Providers of decisions to approve, deny or modify request for authorization of Behavioral Health Services of Members within twenty-four (24) hours of the decision. Members and the Participating Provider are notified of decisions, in writing, within two (2) business days of the decision.

In the case of urgent concurrent review, USBHPC will review and render a decision within no more than seventy-two (72) hours taking into consideration the nature of the Member's condition and provide a response to the Participating Provider within twenty-four (24) hours of the decision. Care shall not be discontinued until the Member's treating provider has been notified of USBHPC's decision, and a care plan has been agreed upon by the treating Participating Provider that is appropriate for the medical needs of the patient. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with USBHPC. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member.

In the case of a request for retrospective services, the total time for making the retrospective review decision and notifying the Participating Provider and Member in writing shall not exceed thirty (30) calendar days from receipt of the claim/request. Written notification of the retrospective review determination is sent to the treating Participating Provider, facility, and Member and/or authorized member representative within thirty (30) days of the retrospective review request.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request" as defined above, USBHPC will modify or deny the request as soon as possible, taking into account the Member's behavioral health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to USBHPC at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, USBHPC will treat the request as a new request for a Covered Service under the Behavioral Health Plan and will follow the time frame for non-Urgent requests as discussed above.

If you would like a copy of USBHPC's description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact the USBHPC Customer Service Department or visit the USBHPC Web site at www.liveandworkwell.com.

Second Opinions

A Member, or his or her treating USBHPC Participating Provider, may submit a request for a second opinion to USBHPC either in writing or verbally through the USBHPC Customer Service Department. Second opinions will be authorized for situations, including, but not limited to, when:

- the Member questions the reasonableness or necessity of recommended procedures;
- the Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition;
- the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Provider is unable to diagnose the condition and the Member requests an additional diagnosis;
- the Treatment Plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- the Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

The request for a second opinion will be approved or denied by USBHPC's Medical Director (or designee) in a timely fashion appropriate for the nature of your or Dependent's condition. For circumstances other than an imminent or serious threat to your health, a second opinion request will be approved or denied within five business days after the Participating Provider or USBHPC receives the request. When there is an imminent and serious threat to your behavioral health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Provider or USBHPC.

If you are requesting a second opinion about care given by your Participating Provider, the second opinion will be provided by an appropriately qualified behavioral health professional of your choice within the same Participating Provider Network. If you request a second opinion about care received from a specialist the second opinion will be provided by any behavioral health care professional of your choice from within the same Participating Provider Network. The Participating Provider providing the second opinion will possess the clinical background, including training and expertise, related to the illness or condition associated with the request for a second opinion.

If there is no qualified Participating Provider within the network, then USBHPC will authorize a second opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, USBHPC will take into account the ability of the Member to travel to the Provider.

A second opinion will be documented by a consultation report which will be made available to you. If the Provider giving the second opinion recommends a particular treatment, diagnostic test or service covered by USBHPC, and it is determined to be Medically Necessary by your Participating Provider, the treatment, diagnostic test or service will be provided or arranged by the Member's Participating Provider. However, the fact that a Provider furnishing a second opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically Necessary or a Covered Service under your USBHPC Behavioral Health Plan. You will be responsible for paying any Copayment, as set forth in your *Schedule of Benefits*, to the USBHPC Provider who renders the second opinion. If you obtain a second opinion without preauthorization from your Participating Provider or USBHPC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, USBHPC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the appeals section described below.

To receive a copy of the Second Opinion policy, you may call or write the USBHPC Customer Service Department at:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, California 94126
1-800-999-9585

How are new treatment and technologies evaluated?

USBHPC is committed to evaluating new treatments and technologies in behavioral health care. A committee composed of USBHPC's Medical Director and people with subject matter expertise meet at least once a year to assess new advances and programs.

Experimental and Investigational Therapies

USBHPC also provides an external independent review process to review its coverage decisions regarding experimental or investigational therapies for USBHPC Members who meet all of the following criteria:

1. You have a Life-Threatening or Seriously Debilitating condition, as defined below and it meets the criteria listed in items #2, #3, #4 and #5 below:
    - "Life-threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.

- "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.

2. Your USBHPC Participating Provider certifies that you have a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by USBHPC than the therapy proposed pursuant to paragraph (3); and

3. Either (a) your USBHPC Participating Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation; or (b) you, or your non-Participating Physician who is a licensed, board-certified or board-eligible Physician or Provider qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from medical and scientific evidence (as defined in California Health and Safety Code Section 1370.4(d)), is likely to be more beneficial for you than any available standard therapy.

   Such certification must include a statement of the evidence relied upon by the Physician in certifying his or her recommendation. USBHPC is not responsible for the payment of services rendered by non-Participating Providers that are not otherwise covered under the Member's USBHPC benefits; and

4. A USBHPC Medical Director (or designee) has denied your request for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3); and

5. The treatment, drug, device, procedure or other therapy recommended pursuant to paragraph 3, above, would be a Covered Service, except for USBHPC's determination that the treatment, drug, device, procedure or other therapy is experimental or investigational. Independent Medical Review for coverage decisions regarding Experimental or Investigational therapies will be processed in accordance with the protocols outlined under "Independent Medical Review Involving a Disputed Health Care Service" Section of this *Evidence of Coverage.*

Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" Section found later in this *Combined Evidence of Coverage and Disclosure Form* for more information.

What to do if you have a problem?

Our first priority is to meet your needs and that means providing responsive service. If you ever have a question or problem, your first step is to call the USBHPC Customer Service Department for resolution.

If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint within 180 days of your receipt of an initial determination over the telephone by calling the USBHPC toll-free number at 1-800-999-9585. You can also file a complaint in writing:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, CA 94126
Attn: Appeals Department

Or at the USBHPC Web site: www.liveandworkwell.com

Appealing a Behavioral Health Benefit Decision

The individual initiating the appeal may submit written comments, documents, records and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The Member may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal. An individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person will review the appeal.

The USBHPC Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances but not later than thirty (30) days after USBHPC's receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial or modifications of Behavioral Health

Services, USBHPC's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying Behavioral Health Services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned USBHPC Quality Review Process.

Binding Arbitration and Voluntary Mediation

If the Member is dissatisfied with the appeal, the Member may submit or request that USBHPC submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Service (JAMS). Such voluntary mediation or binding arbitration will be limited to claims that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Voluntary Mediation – In order to initiate mediation, the Member or agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

Binding Arbitration – Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) between Member (including any heirs, successors or assigns of Member) and USBHPC, except for claims subject to ERISA, shall be submitted to Binding Arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and USBHPC further agree that neither the Court nor any arbitrator shall have the power to delay arbitration of any dispute or to refuse to order any dispute to arbitration, under any provision of section 1281 et seq. of the California Code of Civil Procedure (including, but not limited to, 1281.2(c)), or any successor or replacement provision thereto, of any comparable provision of any other state law. Member and USBHPC further specifically agree that any disputes about the scope of any arbitration or about the arbitration or about the arbitrability of any dispute shall be determined by the arbitrator. Member and USBHPC are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS in effect at the time of the arbitration, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules of JAMS will be utilized.

Arbitration hearings shall be held in Orange County, California, or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship and to prevent any such hardship or unconscionability, USBHPC may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and provided JAMS approves such application. The approval or denial of the hardship application will be determined solely by JAMS. The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision.

The requirement of Binding Arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, restitution, or other monetary relief, shall be subject to Binding Arbitration as provided herein and any claim for permanent injunctive relief shall be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall also apply to the arbitration.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTESBETWEEN THEM RESOLVED IN COURT BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USEOF BINDING ARBITRATION.

Expedited Review Process

Appeals involving an imminent or serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions will be immediately referred to the USBHPC Medical Director for expedited review, regardless of whether such appeal is received orally or in writing. If an appeal has been sent to the USBHPC Medical Director for immediate expedited review, USBHPC will immediately inform the Member, in writing, of his or her right to notify the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three (3) days from receipt of complaint. The Department of Managed Health Care may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 days if the Department of Managed Health Care determines that an earlier review is necessary.

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Service

A Member may request an Independent Medical Review (IMR) of disputed Behavioral Health Services from the Department of Managed Health Care (DMHC) if the Member believes that Behavioral Health Services have been improperly denied, modified or delayed by USBHPC. A "disputed Behavioral Health Service" is any Behavioral Health Service eligible for coverage under the *Evidence of Coverage* that has been denied, modified or delayed by USBHPC, in whole or in part because the service requested by you or your Provider based on a finding that the requested service is experimental or investigational or is not Medically Necessary. The Member must meet the criteria described in the "Eligibility" section to see if his or her grievance qualifies for an IMR. The IMR process is in addition to the procedures and remedies that are available to the Member under the USBHPC Appeal Process described above. If your complaint or appeal pertains to a disputed Behavioral Health Service subject to IMR (as discussed below), you should file your complaint or appeal within 180 days of receiving a denial notice.

Completed applications for IMR should be submitted to the DMHC. The Member pays no fee to apply for IMR. The Member has the right to include any additional information or evidence not previously provided to USBHPC in support of the request for IMR. USBHPC will provide the Member with an IMR application form with any grievance disposition letter that denies, modifies or delays Behavioral Health Services. The Member may also reach the DMHC by calling 1-888-HMO-2219. The DMHC fax number is 1-916-255-5241.

A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against USBHPC regarding the disputed behavioral health service.

IMR Eligibility for Independent Medical Review: Experimental or Investigational Treatment Decisions

If you suffer from a Life-Threatening or Seriously Debilitating condition, you may have the opportunity to seek IMR of USBHPC's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following: (a) conditions where the likelihood of death is high unless the course of the condition is interrupted; (b) conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival. Seriously Debilitating means conditions that cause major irreversible morbidity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Provider certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
    a. Standard therapies have not been effective in improving your condition, or
    b. Standard therapies would not be medically appropriate for you, or
    c. There is no more beneficial standard therapy covered by USBHPC than the proposed Experimental or Investigational therapy proposed by your Provider under the following paragraph.

2. Either (a) your USBHPC Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Provider in certifying his or her recommendation; or (b) you or your non-Participating Provider – who is a licensed, board certified or board-eligible Provider qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Provider certification must include a statement detailing the evidence relied upon by the Provider in certifying his or her recommendation. (Please note that USBHPC is not responsible for the payment of services rendered by non-Participating Providers who are not otherwise covered under your USBHPC benefits.)
3. A USBHPC Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for USBHPC's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and USBHPC denies your request for Experimental or Investigational therapy, USBHPC will send a written notice of the denial within five business days of the decision. The notice will advise you of your right to request IMR, and include a Provider certification form and an application form with a preaddressed envelope to be used to request IMR from the DMHC. (Please note that you may request an IMR, if USBHPC denied your request for Experimental or Investigational therapy, without going through the USBHPC grievance process.)

Disputed Behavioral Health Services Regarding Medical Necessity

You may also request IMR when any Behavioral Health Service has been denied, modified or delayed by USBHPC or one of its Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (Note: Disputed Behavioral Health Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Behavioral Health Service if you meet all of the following criteria:

- The Member's Provider has recommended a Behavioral Health Service as Medically Necessary; or
- The Member has received Urgently Needed Services or Emergency Services that a Provider determined was Medically Necessary; or
- The Member has been seen by a USBHPC Participating Provider for diagnosis or treatment of the medical condition for which the Member sought independent review;
- The disputed Behavioral Health Service has been denied, modified or delayed by USBHPC, based in whole or in part on a decision that the Behavioral Health Service is not Medically Necessary; and
- The Member has filed a grievance with USBHPC and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If the grievance requires expedited review, the Member may bring it immediately to the DMHC's attention. The DMHC may waive the preceding requirement that the Member follow USBHPC's grievance process in extraordinary and compelling cases.

Accepted Applications for the Independent Medical Review

Upon receiving a Member's application for IMR, the DMHC will review the request and notify the Member whether the Member's case has been accepted. If the Member's case is eligible for IMR, the dispute will be submitted to an independent medical review organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of USBHPC, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of behavioral health professionals knowledgeable in the treatment of the Member's conditions, the

proposed treatment and the guidelines and protocols in the area of treatment under review. Neither the Member nor USBHPC will control the choice of expert reviews.

USBHPC must provide the following documents to the IRO within three business days of receiving notice from the DMHC that the Member has successfully applied for an IMR:

- The relevant medical records in the possession of USBHPC or its Participating Providers;
- All information provided to the Member by USBHPC and any of its Participating Providers concerning USBHPC and Participating Provider decision regarding the Member's condition and care (including a copy of USBHPC's denial notice sent to the Member).
- Any materials that the Member or Provider submitted to USBHPC and its Participating Providers in support of the request for the Behavioral Health Services.
- Any other relevant documents or information used by USBHPC or its Participating Providers in determining whether the Behavioral Health Services should have been provided and any statement by USBHPC or its Participating Providers explaining the reason for the decision. USBHPC will provide copies of these documents to the Member and the Member's Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to the Member's health, USBHPC will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required materials to the IRO, USBHPC will promptly issue the Member a notification that includes an annotated list of the documents submitted and offer the Member the opportunity to request copies of those documents from USBHPC.

If there is any information or evidence the Member or the Member's Provider wish to submit to the DMHC in support of IMR that was not previously provided to USBHPC, the Member may include this information with the IMR application to the DMHC. Also as required, the Member or the Member's Provider must provide to the DMHC or the IRO copies of any relevant behavioral health records, and any newly developed or discovered relevant records after the initial documents are provided, and respond to any requests for additional records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on the Member's IMR case in writing, and in layperson terms to the maximum extent practical, within 30 days of receiving the Member's request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of Experimental or Investigational determination, if the Member's Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.
- If the Behavioral Health Services has not been provided and the Member's Provider or the DMHC certifies in writing that an imminent and serious threat to the Member's life exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the Member's health. In this instance, any analyses and recommendation of the experts must be expedited and rendered within three days of the receipt of the Member's application and supporting information.
- If approved by the DMHC, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.
- The IRO will provide the DMHC, USBHPC, the Member and the Member's Provider with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the Member than any available standard

therapy and the reasons for recommending why the therapy should or should not be provided by USBHPC, citing the Member's specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the Behavioral Health Services should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the Behavioral Health Services, USBHPC will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on USBHPC. USBHPC will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, USBHPC will reimburse either the Member or the Member's Provider, whichever applies, within five working days. In the case of services not yet rendered to the Member, USBHPC will authorize the services within five working days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of the Member's medical condition and will inform the Member and the Member's Provider of the authorization.

USBHPC will promptly reimburse the Member for reasonable costs associated with Urgently Needed Services or Emergency Services outside of USBHPC Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds the Member's decision to secure services outside of USBHPC's Participating Provider network prior to completing the USBHPC grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the disputed health care services were a covered benefit under the USBHPC Group Subscriber Agreement.

Behavioral Health Services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under USBHPC Plan.

For more information regarding the IMR process, or to request an application, the Member should contact the USBHPC Customer Service Department at 1-800-999-9585.

The USBHPC Quality Review Process

The quality review process is a Member-initiated internal review process that addresses Member concerns regarding the quality or appropriateness of services provided by USBHPC Participating Providers that has the potential for an adverse effect on the Member. Upon receipt of the Member's concern, the concern is referred to the Quality Improvement Department for investigation.

USBHPC takes great pride in the quality of our Participating Providers. That is why complaints specifically about the quality of the care you receive from your Participating Provider are handled in an expedited fashion. Quality of care complaints that affect a Member's current treatment will be immediately evaluated and if necessary, other appropriate USBHPC personnel and the USBHPC Participating Provider will be consulted.

The Quality Improvement Manager (or designee) will be responsible for responding to questions the Member may have about his or her complaint and about the Quality Review process. In appropriate instances, a meeting may be arranged between the Member and the Participating Provider.

The relevant medical records will be obtained from the appropriate Providers and reviewed by the USBHPC Quality Improvement Manager (or designee). If necessary, a letter is sent to the Participating Provider, as appropriate, requesting further information. Additional information will be received and reviewed by the Quality Improvement Manager (or designee). After reviewing the medical records, the case may be referred to the Peer Review Committee for review and recommendation of corrective action against the USBHPC Participating Provider involved, if appropriate.

If the Member has submitted a written complaint, the Member will be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Review Process and the results of the review are confidential and cannot be shared with the Member. The outcome of the Quality Review Process cannot be submitted to voluntary mediation or binding arbitration as described above under the USBHPC Appeals Process. The Quality Improvement Manager will follow-up to ensure that any corrective actions against a Participating Provider are carried out.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-999-9585** or **711 for TTY (at operator request, enter "1-800-999-9585")** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal right or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature and payment disputes for Emergency or Urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

SECTION 6. GENERAL INFORMATION

- **What if I get a Bill?**
- **Your Financial Responsibilities**
- **Termination of Benefits**
- **Confidentiality of Information**
- **Language Interpretation and Translation Services**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Suspected Health Care Fraud**
- **Public Policy Participation**

What follows are answers to some questions about your coverage. If you have any questions of your own that have not been answered, please call our Customer Service Department.

What if I get a bill?

You should not get a bill from you USBHPC Participating Provider because USBHPC's Participating Providers have been instructed to send all their bills to us for payment. You may, however, have to pay a Copayment to the Participating Provider each time you receive services. You could get a bill from an emergency room Provider if you use Emergency care. If this happens, send USBHPC the original bill or claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your Copayment, as described in the *Schedule of Benefits* in this *Evidence of Coverage and Disclosure Form*.

Forward the bill to:

U.S. Behavioral Health Plan, California
Claims Department
P.O. Box 30602
Salt Lake City, UT 84130-0602

Your Financial Responsibility

Please refer to the "Payment Responsibility" section of your UnitedHealthcare of California Medical *Combined Evidence of Coverage and Disclosure Form.*

Termination of Benefits

Please refer to the "Termination of Benefits" section of your UnitedHealthcare of California Medical *Combined Evidence of Coverage and Disclosure Form*.

Confidentiality of Information

USBHPC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all Member information in its possession, including the protection of treatment records and personal information. USBHPC provides information only to the professionals delivering your treatment or as otherwise required by law.

Confidentiality is built into the operations of USBHPC through a system of control and security that protects both written and computer-based information.

A statement describing USBHPC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. If you would like a copy of USBHPC's confidentiality policies and procedures, you may call our Customer Service Department at 1-800-999-9585.

Does USBHPC offer language interpretation and translation services?

USBHPC uses a telephone interpretation service for almost 140 languages and dialects. That is in addition to the selection of Customer Service representatives who are fluent in a language other than English. Please refer to the USBHPC Participating Provider Directory at www.liveandworkwell.com for specific language interpretation availability. Certain translated member materials are also available upon request by calling USBHPC's Customer Service Department at 1-800-999-9585.

Does USBHPC offer hearing and speech-impaired telephone lines?

USBHPC uses a national TTY (text telephone) relay service for the hearing and speech impaired. To use this service, dial 711 and at the operator's request, say or enter 1-800-999-9585.

How is my coverage provided under extraordinary circumstances?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Providers will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. USBHPC will later provide appropriate reimbursement.

How does USBHPC compensate its Participating Providers?

USBHPC itself is not a Provider of Behavioral Health Services. USBHPC typically contracts with independent Providers to provide Behavioral Health Services to its Members and with hospitals to provide hospital services. Once they are contracted, they become USBHPC Participating Providers. USBHPC's network of Participating Providers includes individuals practitioners, group practices and facilities.

USBHPC Participating Providers who are groups, or facilities may in turn employ or contract with individual psychiatrists, psychologists or other licensed behavioral health professionals. None of the Participating Providers or their employees are employees or agents of USBHPC. Likewise, neither USBHPC nor any employee of USBHPC is an employee or agent of any Participating Provider.

Our USBHPC Participating Providers are paid on a discounted fee-for-service basis for the services they provide. They have agreed to provide services to you at the normal fee they charge, minus a discount. USBHPC does not compensate nor does it provide any financial bonuses or any other incentives to its Providers based on their utilization patterns.

If you would like to know more about fee-for-service reimbursement, you may request additional information from the USBHPC Customer Service Department or your USBHPC Participating Provider.

What do you do if you suspect health care fraud?

USBHPC takes health care fraud by its Participating Providers or by its employees very seriously and has taken great measures to prevent, detect and investigate health care fraud. USBHPC has put in place policies and procedures to address fraud and report fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of health care fraud. If you suspect fraud by any USBHPC Participating Provider or any USBHPC employee, please call the USBHPC anti-fraud hotline at 1-800-455-4521.

How can I participate in USBHPC'S Public Policy Participation?

USBHPC affords its Members the opportunity to participate in establishing its public policy. For the purpose of this paragraph, "public policy" means acts performed by USBHPC and its employees to assure the comfort, dignity and convenience of Members who rely on Participating Providers to provide Covered Services. USBHPC members comprise at least 51% of USBHPC's Public Policy Committee. If you are interested in participating in USBHPC's public policy, please call the USBHPC Customer Service Department for more details.

SECTION 7. DEFINITIONS

U.S. Behavioral Health Plan, California is dedicated to making its services easily accessible and understandable. To help you understand the precise meaning of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Combined Evidence of Coverage and Disclosure Form, as well as the Schedule of Benefits. Please refer to the Schedules of Benefits to determine which of the definitions below apply to your benefit plan.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders including but not limited to treatment for the Severe Mental Illness of a Person of Any Age and/or the Serious Emotional Disturbance of a Child under the Age of 18, and/or services for the treatment of Substance-Related and Addictive Disorders**,** which are provided to Members pursuant to the terms and conditions of the USBHPC Behavioral Health Plan.

Behavioral Health Plan. The USBHPC Behavioral Health Plan that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and Substance-Related and Addictive Disorder, as described in the Behavioral Health Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits*.

Behavioral Health Treatment ("BHT") -. Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a licensed physician and surgeon of the California Business and Professions Code or developed by a licensed Participating psychologist pursuant to the California Business and Professions Code as authorized under California law.
- The treatment is provided under a treatment plan prescribed by a Participating Qualified Autism Service Provider and is administered by one of the following
- A Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Professional supervised and employed by the Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Paraprofessional supervised and employed by a Participating Qualified Autism Service Provider.

The treatment plan has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the Participating Qualified Autism Service Provider does all of the following:

- Describes the Member's behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

Behavioral Health Treatment Plan. A written clinical presentation of the USBHPC Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to a USBHPC for review as part of the concurrent review monitoring process.

Behavioral Health Treatment Program. A structured treatment program aimed at the treatment and alleviation of Substance-Related and Addictive Disorder and/or Mental Disorders.

Benefit Plan Design. The specific behavioral health Benefit Plan Design for a Behavioral Health Plan which describes the benefit coverage, pertinent terms and conditions for rendering Behavioral Health Services, and the exclusions or limitations applicable to the Covered Behavioral Health Services.

Calendar Year. The period of time commencing 12 a.m. on January 1 through 11:59 p.m. on December 31.

Case Management. A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral health needs based on Medical Necessity, behavioral health benefits and available resources in order to promote a quality outcome for the individual Member.

Continuity of Care Condition(s). The completion of Covered Services will be provided by a terminated Participating Provider to a Member who at all time of the Participating Provider's contract termination was receiving any of the following Covered Services from that Participating Provider:

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.
2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time reasonably necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Provider, as determined by the USBHPC Medical Director (or designee) in consultation with the Member, the terminated Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination.
3. Other Procedure: Other procedure that has been authorized by USBHPC or the Member's assigned Participating Provider as part of a documented course of treatment and had been recommended and documented by the terminated Participating Provider to occur within 180 calendar days of the Agreement's termination date.

Copayments. Costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of covered charges as specified in this *Combined Evidence of Coverage and Disclosure Form* and are shown on the USBHPC *Schedule of Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* for Emergencies or those Behavioral Health Services.

Custodial Care. Care and services required that assist the Member in the activities of daily living. Examples include assistance in walking, getting in or out of bed, bathing, dressing, feeding or using the toilet, preparation of special diets and supervision of medication that usually can be self-administering. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care is not covered under this USBHPC Behavioral Health Plan.

Customer Service Department. The department designated by USBHPC to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-800-999-9585 or in writing at:

U.S. Behavioral Health Plan, California
Post Office Box 2839
San Francisco, California 94126

Day Treatment Center. A Participating Facility which provides a specific Behavioral Health Treatment Program on a full- or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Participating Practitioner and which is also licensed, certified or approved to provide such services by the appropriate state agency.

Dependent. Any Member of a Subscriber's family who meets all the eligibility requirements set forth by the Employer Group under this USBHPC Behavioral Health Plan and for whom applicable Plan Premiums are received by USBHPC.

Developmental Delay. A delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.

Diagnostic and Statistical Manual (*or "DSM"*). The *Diagnostic and Statistical Manual of Mental Disorders*, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Substance-Related and Addictive Disorder and Mental Disorders.

Domestic Partner is a person who meets the eligibility requirements, as defined by your Employer Group, and the following:

i. Is eighteen (18) years of age or older. An exception is provided to Subscribers and/or Dependents less than 18 years of age who have, in accordance with California Law, obtained:

- Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.

- A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.

ii. Is mentally competent to consent to contract.

iii. Is unmarried or not a member of another domestic partnership.

iv. Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Emergency or Emergency Services. A behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the Prudent Layperson would expect the absence of immediate Behavioral Health Services to result in any of the following:

- Immediate harm to self or others;
- Placing one's health in serious jeopardy;
- Serious impairment of one's functioning; or
- Serious dysfunction of any bodily organ or part.

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the 911 Emergency response system and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if an Emergency for a Behavioral Health condition exists, and if it does, the care and treatment by a Practitioner necessary to relieve or eliminate the Emergency within the capabilities of the facility.

Experimental and Investigational. Please refer to the "Experimental and Investigational Therapies" section of this *Combined Evidence of Coverage and Disclosure Form*.

Employer Group. An employer, labor union, trust, organization, association or other entity to which the USBHPC Group Subscriber Agreement has been issued.

Family Member. The Subscriber's legal spouse or Domestic Partner and any person related to the Subscriber, legal spouse or Domestic Partner by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with USBHPC, meets all the eligibility requirements of the Subscriber's Employer Group and USBHPC, and for whom Premiums have been received by USBHPC. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and USBHPC.

Group Subscriber Agreement. The Agreement for the provision of Behavioral Health Services between the Group and USBHPC.

Inpatient Treatment Center. An acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Participating Practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.

Learning Disability. A condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

Limiting Age. The age established by the Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage. In no event shall the Limiting Age be less than 26 years of age.

Medical Detoxification. The medical treatment of withdrawal from alcohol, drug or other substance addiction is covered.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of USBHPC to be all of the following:

a. A health intervention for the purpose of treating a Mental Disorder or Substance-Related and Addictive Disorder;

b. The most appropriate level of service or item, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

A service or item will be covered under the USBHPC Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meaning:

i. *Treating Practitioner* means a Practitioner who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnosis, detect, treat or palliate) a Mental Disorder or Substance-Related and Addictive Disorder or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder and Substance-Related and Addictive Disorder condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the Mental Disorder or Substance-Related and Addictive Disorder condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis

for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A *new intervention* is one that is not yet in widespread use for the Mental Disorder or Substance-Related and Addictive Disorder and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

Member. The Subscriber or any Dependent who is enrolled, covered and eligible for USBHPC Behavioral Health Care coverage.

Mental Disorder. A mental health condition identified as a "mental health disorder" in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) that results in clinically significant distress or impairment of mental, emotional or behavioral functioning. Mental Disorders also include the Severe Mental Illness of a Person of Any Age and the Serious Emotional Disturbance of a Child, as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Please refer to the definitions of Severe Mental Illness and Serious Emotional Disturbance of a Child, respectively, in this Section 7, **Definitions.**

Mental Health Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders, including but not limited to Severe Mental Illness and A Serious Emotional Disturbance of a Child, and services for the treatment of Substance-Related and Addictive Disorders.

Non-Participating Providers. Licensed psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and other behavioral health professionals; qualified autism service providers, professionals and paraprofessionals; hospitals and other licensed behavioral health facilities which provide Behavioral Health Services to eligible Members, but have not entered into a written agreement with USBHPC to provide such services to Members.

Outpatient Treatment Center. A licensed or certified Participating Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment. A structured ambulatory program that may be freestanding or hospital-based and that provides services for at least five (5) hours per day and at least four (4) days per week. Partial hospital programs are used as a step-up from routine or intensive outpatient services, or as a step-down from acute inpatient or residential care. Partial hospital programs can be used to treat mental health conditions or substance-related and addictive disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-related and addictive disorders.

Participating Facility. An Inpatient Treatment Center, Day Treatment Center, Outpatient Treatment Center or Residential Treatment Center which is duly licensed in the State of California to provide either acute inpatient treatment, partial hospitalization, day treatment or outpatient care for the diagnosis and/or treatment of Mental Disorders and/or Substance-Related and Addictive Disorder, and which has entered into a written agreement with USBHPC.

Participating Practitioner. A psychiatrist, psychologist, nurse practitioner or other allied behavioral health care professional who is qualified and duly licensed and acting within the scope of their license, certified or otherwise authorized to practice his or her profession under the laws of the State of California and who has entered into a written agreement with USBHPC to provide Behavioral Health Services to Members.

Participating Providers. Participating Practitioners, Participating Qualified Autism Service Providers, Participating Provider Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with USBHPC to provide Behavioral Health Services to Members.

Participating Group Practice. A Provider group, entity or independent practice association duly organized and licensed, certified or otherwise authorized under the laws of the State of California to provide Behavioral Health Services through agreements with individual behavioral health care Providers, each of whom is qualified and appropriately licensed, certified or otherwise authorized to practice his or her profession in the State of California.

Participating Qualified Autism Service Provider - either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, or as authorized under California law, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Participating Qualified Autism Service Professional - an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment.
- Is employed and supervised by a Participating Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code or is otherwise authorized under California law.

Participating Qualified Autism Service Paraprofessional - an unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is employed and supervised by a Participating Qualified Autism Service Provider.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.
- Has adequate education, training, and experience, as certified by a Participating Qualified Autism Service Provider.

Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California.

Premiums. The periodic, fixed-dollar amount payable to USBHPC by the Employer Group for or on behalf of the Subscriber and the Subscriber's eligible Dependents in consideration of Behavioral Health Services provided under this Plan.

Psychiatric Emergency Medical Condition. A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

(A) An immediate danger to himself or herself or to others

(B) Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Psychological and Neuropsychological Testing – Psychological and Neuropsychological Testing includes the administration, interpretation, and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Residential Treatment Center. A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including but not limited to Mental Disorders and Substance-Related and Addictive Disorders and which is licensed, certified or approved as such by the appropriate state agency.

Schedule of Benefits. The schedule of Behavioral Health Services which is provided to a Members under this Behavioral Health Plan. The *Schedule of Benefits* is attached and incorporated in full and made a part of this document.

Serious Emotional Disturbance of a Child (SED) Under Age 18. A Serious Emotional Disturbance of a Child under Age 18 means a condition identified as a Mental Disorder in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), other than a primary substance-related and addictive disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

- As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either:
  - (i) the child is at risk of removal from home or has already been removed from the home; or
  - (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays psychotic features or risk of suicide or violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Service Area. The geographic area in which USBHPC is licensed to arrange for Behavioral Health Services in the State of California by the California Department of Managed Health Care.

Severe Mental Illness (SMI) of a Person of any Age. Severe Mental Illness of a person of any age includes the diagnosis and treatment of the following Mental Disorders:

- Anorexia Nervosa
- Bipolar Disorder (manic-depressive illness)
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or autism, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder

- Schizophrenia

Subscriber. The person whose employment or other status except for being a Family Member, is the basis for eligibility to enroll in the USBHPC Behavioral Health Plan and who meets all the applicable eligibility requirements of the Group and USBHPC and for whom Plan Premiums have been received by USBHPC.

Substance-Related and Addictive Disorder. An addictive relationship between a Member and any drug, alcohol or chemical substance. Substance-Related and Addictive Disorder does not include addiction to or dependency on (1) tobacco in any form or (2) caffeine in any form.

Substance-Related and Addictive Disorder Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of Substance-Related and Addictive Disorder**.**

Substance-Related and Addictive Disorder Services. Medically Necessary services provided for the diagnosis and treatment of Substance-Related and Addictive Disorder**.**

Telehealth. The mode of delivering Covered Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

• "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.

• "Distant site" means a site where a licensed health care provider who provides Covered Services is located while providing these services via a telecommunications system.

• "Originating site" means a site where a patient is located at the time Covered Services are provided via a telecommunications system or where the asynchronous store and forward service originates.

• "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Totally Disabled or Total Disability. The persistent inability to engage reliably in any substantially gainful activity by reason of any determinable physical or mental impairment resulting from an injury or illness. Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of a medically determinable physical or mental impairment resulting from an injury or illness. The disability must be related to a Behavioral Health condition, as defined in the *DSM*, in order to qualify for coverage under this USBHPC Plan. Determination of Total Disability shall be made by a USBHPC Participating Provider based upon a comprehensive psychiatric examination of the Member or upon the concurrence by a USBHPC Medical Director, if on the basis of a comprehensive psychiatric examination by a non-USBHPC Participating Provider.

Transitional Residential Recovery Services. Substance-Related and Addictive Disorder or chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

Treatment Plan. A structured course of treatment authorized by a USBHPC Clinician, when appropriate, and for which a Member has been admitted to a Participating Facility, received Behavioral Health Services, and been discharged.

Urgent or Urgently Needed Services. Medically Necessary Behavioral Health Services received in an urgent care facility or in a Provider's office for an unforeseen condition to prevent serious deterioration of a Member's health resulting from an

unforeseen illness or complication of an existing condition manifesting itself by acute symptoms of sufficient severity, such that treatment cannot be delayed.

USBHPC Clinician. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse or other health care professional licensed, certified or otherwise authorized under California law with appropriate training and experience in Behavioral Health Services, who is employed or under contract with USBHPC related to managing Covered Behavioral Health Services.

Visit. An outpatient session with a USBHPC Participating Practitioner conducted on an individual or group basis during which Behavioral Health Services are delivered.

NOTE: IN ORDER TO FULLY UNDERSTAND YOUR BENEFIT PLAN, THIS USBHPC *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* IS TO BE USED IN CONJUNCTION WITH YOUR UNITEDHEALTHCARE OF CALIFORNIA MEDICAL PLAN *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.* PLEASE READ BOTH DOCUMENTS CAREFULLY.

P.O. Box 2839
San Francisco, CA 94126

Customer Service:
800-999-9585
711 (TTY)
www.liveandworkwell.com

PCA787985-000

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Combined Evidence of Coverage and Disclosure Form

COMBINED EVIDENCE OF COVERAGE

AND DISCLOSURE FORM

ACUPUNCTURE AND CHIROPRACTIC HEALTH BENEFITS PLAN

This "*Combined Evidence of Coverage and Disclosure Form*" discloses the terms and conditions of coverage. However, it constitutes only a summary of your acupuncture and chiropractic health benefits plan. The document entitled "Group Enrollment Agreement" must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Group Enrollment Agreement will be furnished upon request. You have the right to review this *Combined Evidence of Coverage and Disclosure Form* prior to enrollment. If you have special health care needs, review this *Combined Evidence Of Coverage and Disclosure Form* completely and carefully to determine if this benefit provides coverage for your special needs.

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INTRODUCTION

This document describes the terms under which ACN Group of California, Inc. *dba OptumHealth Physical Health of California* will provide an acupuncture and chiropractic benefits program to employees of **Employer Group** and their Family Dependents who have enrolled under the Group Enrollment Agreement between *OptumHealth Physical Health of California* and **Employer Group.**

Throughout this document, *OptumHealth Physical Health of California* will be referred to as the "Health Plan," **Employer Group** will be referred to as the "Group," and enrollees under the Group Enrollment Agreement will be referred to as "Members." Along with reading this publication, be sure to review the *Schedule of Benefits* and any benefit materials. The *Schedule of Benefits* provides the details of this particular Health Plan, including any Copayments that a member may have to pay when using a health care service. Together, these documents explain this coverage.

SECTION 1. DEFINITIONS

This Section defines some important words and phrases that are used throughout this document. Understanding the meanings of these words and phrases is essential to an understanding of the overall document.

1.1 Acupuncture Disorder

"Acupuncture Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders or other conditions wherein Acupuncture Services can reasonably be anticipated to result in improvement.

1.2 Acupuncture Services

"Acupuncture Services" means Medically Necessary services and supplies provided by or under the direction of a Participating Provider for the treatment or diagnosis of Acupuncture Disorders.

1.3 Acupuncturist

"Acupuncturist" means an individual duly licensed to practice acupuncture in California.

1.4 Annual Benefit Maximum

"Annual Benefit Maximum" means an amount specified in the *Schedule of Benefits* which is the maximum amount that Health Plan is obligated to pay on behalf of a Subscriber for Covered Services of a particular type or category provided to a Subscriber in a given benefit year.

1.5 Chiropractic Disorder

"Chiropractic Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders, wherein Chiropractic Services can reasonably be anticipated to result in improvement.

1.6 Chiropractic Services

"Chiropractic Services" means Medically Necessary services and supplies provided by or under the direction of a Participating Provider for the diagnosis of treatment of Chiropractic Disorders.

1.7 Chiropractor

"Chiropractor" means an individual duly licensed to practice chiropractics in California.

1.8 Copayment

"Copayment" means a predetermined amount specified in the *Schedule of Benefits* to be paid by the Member each time a specific Covered Service is received. Copayments are to be paid by Members directly to the Participating Provider who or which provided the Covered Service(s) to which such Copayments apply.

1.9 Coverage Decision

"Coverage Decision" means the approval or denial of benefits for health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a Disputed Health Care Service.

1.10 Covered Services

"Covered Services" means those Medically Necessary Chiropractic Services or Acupuncture Services, including Urgent Services, to which Members are entitled under the terms of the Group Enrollment Agreement and this *Combined Evidence Of Coverage and Disclosure Form*, as such documents may be amended from time to time in accordance with their terms.

1.11 Department

"Department" means the California Department of Managed Health Care.

1.12 Disputed Health Care Service

"Disputed Health Care Service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not Medically Necessary.

1.13 Domestic Partner

"Domestic Partner" means a person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is eighteen (18) years of age or older;
- Is mentally competent to consent to contract;
- Resides with the Subscriber and intends to do so indefinitely;
- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

1.14 Emergency Services

"Emergency Services" means services provided for a medical condition (including a psychiatric medical condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part.

1.15 Exclusion

"Exclusion" means any service, equipment, supply, accommodation or other item specifically listed or described as excluded in the Group Enrollment Agreement or this *Combined Evidence Of Coverage and Disclosure Form*.

1.16 Family Dependent

"Family Dependent" means an individual who is a member of a Subscriber's family and who is eligible and enrolled in accordance with all applicable requirements of the Group Enrollment Agreement, and on whose behalf Health Plan has received premiums.

1.17 Group Enrollment Agreement

"Group Enrollment Agreement" means the agreement entered into by and between ACN Group of California, Inc. of California and Group through which you enroll for coverage.

1.18 Limitation

"Limitation" means any provision, other than an Exclusion, contained in the Group Enrollment Agreement, this *Combined Evidence Of Coverage and Disclosure Form* or the attached *Schedule of Benefits*, which limit the covered Chiropractic Services or Acupuncture Services to which Members are entitled.

1.19 Medically Necessary

"Medically Necessary" means:

a. **Chiropractic:** Necessary and appropriate for the diagnosis or treatment of neuromusculoskeletal disorders; established as safe and effective; and furnished in accordance with generally accepted chiropractic practice and professional standards to treat Neuromusculoskeletal Disorders.

b. **Acupuncture:** Necessary and appropriate for the diagnosis or treatment of an accident, illness or condition; established as safe and effective; and furnished in accordance with generally accepted acupuncture practice and professional standards.

1.20 Member

"Member" means a Subscriber or a Family Dependent.

1.21 Negotiated Rates Schedule

"Negotiated Rates Schedule" means the schedule of rates which a Participating Provider has agreed to accept as payment in full for Covered Services provided to Members.

1.22 Neuromusculoskeletal Disorders

"Neuromusculoskeletal Disorders" means conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction is the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related to neurological manifestations or conditions.

1.23 Participating Provider

"Participating Provider" means any Chiropractor or Acupuncturist who is qualified and duly licensed or certified by the State of California to furnish Chiropractic Services or Acupuncture Services and has entered into a contract with the Health Plan to provide Covered Services to Members.

1.24 *Schedule of Benefits*

"*Schedule of Benefits*" means the summary of Copayments, Annual Benefit Maximums, Exclusions and Limitations applicable to Member's chiropractic and acupuncture benefits program. The *Schedule of Benefits* is Attachment A to this *Combined Evidence Of Coverage and Disclosure Form*.

1.25 Subscriber

"Subscriber" means an employee or retiree who is eligible and enrolled in accordance with all applicable requirements of this Agreement, and on whose behalf the Group has made premium payments.

1.26 Urgent Services

"Urgent Services" means services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

SECTION 2. RENEWAL PROVISIONS

After the Initial Term, the Group Enrollment Agreement will automatically renew from year to year for additional twelve (12)-month periods ("Subsequent Terms") on the same terms and conditions unless terminated by the Group in accordance with Section 22 of the Group Enrollment Agreement. However, Health Plan has reserved the right to change the Premium Rate Schedule in accordance with Section 5.4 of the Group Enrollment Agreement and any other term or condition of the Group Enrollment Agreement upon thirty-one (31) days' prior written notice to the Group.

SECTION 3. PREPAYMENT OF FEES

3.1 Premium Rate Schedule

The Group is responsible for timely payment to Health Plan of the applicable total monthly premium. The Group will notify Members of the portion of that charge, if any, which Members are required to pay. The only other charges to be paid by Members are the Copayments for the Covered Services received. The full premium cost per Member will be **as determined by Group**.

3.2 Premium Due Date and Payments

The first day of a month of coverage under the Group Enrollment Agreement is called the "Premium Due Date." The Group has agreed to pay to Health Plan on or before the Premium Due Date the applicable total monthly premium for each Member enrolled as of such date as determined by Health Plan by reference to Health Plan Member records.

Premium payments which remain outstanding subsequent to the end of the grace period shall be subject to a late penalty charge of one percent (1.00%) of the total premium amount due calculated for each thirty-one (31)-day period or portion thereof during which the premium remains outstanding. In addition, subject to Section 17 of this *Combined Evidence Of Coverage and Disclosure Form*, Health Plan may terminate coverage of a Member whose premium is unpaid. Only Members for whom payment is received by Health Plan will be eligible for Covered Services, and then only for the period covered by such payments.

3.3 Premium Adjustments

If a Member enrolls on or before the 15th day of a month, Group has agreed to pay to Health Plan on or before the next Premium Due Date an additional total monthly premium for such Member for the month in which the Member enrolled. In the event that a Member enrolls after the 15th day of the month, no total monthly premium is due for such Member for the month in which the Member enrolled.

3.4 Premium Rate Schedule Changes

Health Plan may change the Premium Rate Schedule at the end of the Initial Term or any Subsequent Term by giving no less than thirty-one (31) days' prior written notice to the Group. The Premium Rate Schedule will not be revised more often than one (1) time during each Initial Term and one (1) time during each of any Subsequent Term/s. However, if a change in the Group Enrollment Agreement is necessitated by a change in the applicable law or in the interpretation of applicable law, and if such change results in an increase of Health Plan's risk or expenses under the Group Enrollment Agreement, or if there is a material change in the number of eligible subscribers of the Group, Health Plan may change the Premium Rate Schedule at any time upon thirty-one (31) days' prior written notice to the Group pursuant to the Group Enrollment Agreement requirements. Any such change will not be taken into account in determining whether the foregoing limits on revisions to the Premium Rate Schedule have been reached.

SECTION 4. OTHER CHARGES

Each Member is personally responsible for all Copayments listed in the *Schedule of Benefits* applicable to Covered Services received by the Member. Members must pay all applicable Copayments to the Participating Provider who provided the Covered Services to which such payments apply at the time such services are rendered.

SECTION 5. ELIGIBILITY

5.1 Subscriber and Family Dependents

To be eligible to enroll as a Subscriber in this benefit plan, a person must meet the eligibility guidelines established by the Group.

If the Group does not have eligibility guidelines, Health Plan will use the following guidelines for eligibility:

5.1.1 Full-time employees working thirty (30) or more hours per week.

5.1.2 Family Dependents who are persons listed on an enrollment form completed by the Subscriber, and are one of the following:

5.1.2.1 The Subscriber's lawful spouse in a marriage that has been duly licensed and registered in accordance with the laws of the jurisdiction in which it occurred or Domestic Partner; or

5.1.2.2 A child or stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner by birth, legal adoption or court appointed legal guardianship, under the age of twenty-six (26) or as required by state or federal laws or regulations; if adopted, such child is eligible on the date the child was in custody of the Subscriber or the Subscriber's spouse or Domestic Partner; or

5.1.2.3 A child as defined in Section 5.1.2.2 above who is, and continues to be, both incapable of self-sustaining employment by reason of mental or physical handicap, and chiefly dependent upon the Subscriber for economic support and maintenance, provided that such child meets the requirements of either (A) or (B) below:

(A) The child is a Family Dependent continuously enrolled hereunder prior to attaining the applicable limiting age, and proof of such incapacity and dependency is furnished to Health Plan by the Subscriber within thirty-one (31) days of the child's attainment of the applicable limiting age; or

(B) The handicap started before the child reached the applicable limiting age, and the Group was previously enrolled in another health benefits program that included chiropractic or acupuncture benefits that covered the child as a handicapped dependent immediately prior to the Group enrolling with Health Plan.

(C) Subsequent proof of continuing incapacity and dependency may be required by Health Plan, but not more frequently than annually after the two-year period following the child attaining the applicable limiting age. Health Plan's determination of eligibility is conclusive; or

A newborn child of the Subscriber or Subscriber's spouse. Such newborn children automatically have coverage for the first thirty-one (31) days of life. Coverage after thirty-one (31) days is conditioned on the Subscriber enrolling the newborn as a Family Dependent, and paying any applicable premium and charges due and owing from the date of birth, within thirty-one (31) days following birth.

The following are not considered Family Dependents:

(A) A foster child

(B) A grandchild

5.1.3 Eligible persons must reside in the U.S.

5.1.4 If both spouses or Domestic Partners are eligible persons of the Group, each may enroll as a Subscriber or be covered as an enrolled Family Dependent of each other, but not both.

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

5.2 Changes in Eligibility

The Subscriber is responsible for notifying the Group of any changes that affect the eligibility of the Subscriber or a Family Dependent for coverage. Any changes which affect a Subscriber's eligibility status including, but not limited to, death, divorce, marriage, or attainment of limiting age, require notice to Health Plan from the Subscriber or the Group within thirty-one (31) days of the date of the change in status. Coverage for a Member who no longer meets applicable eligibility requirements shall terminate upon the earlier of: (i) Health Plan’s receipt of written notice of the Member’s change in status; or (ii) the last day of the calendar month in which eligibility ceased.

5.3 Nondiscrimination

Except as otherwise provided in the Group Enrollment Agreement, Health Plan will require Participating Providers to make Covered Services available to Members in the same manner, in accordance with the same standards, and with no less availability as Participating Providers provide services to their other patients. Participating Providers shall not discriminate against any Members in the provision of Covered Services on account of race, sex, color, religion, national origin, ancestry, age, physical or mental handicap, health status, disability, genetic characteristics, need for medical care, sexual preference, or veteran’s status.

5.4 Medicare

Benefits under the benefit plan are not intended to supplement any coverage provided by Medicare. In some circumstances, Members who are eligible for or enrolled in Medicare may also be enrolled under the benefit plan, subject to Section 11.

SECTION 6. ENROLLMENT

6.1 Initial Enrollment

Members who elect enrollment through the Group are automatically enrolled for coverage under the benefit plan by the Group.

6.2 Special Enrollment Period

Subscribers who do not enroll for coverage when first eligible may enroll themselves and Family Dependents for coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (i) The eligible Subscriber and/or Family Dependents had existing health coverage under another plan at the time of initial eligibility; or (ii) Coverage under the prior plan was terminated as a result of loss of eligibility. Subscribers must enroll themselves and any eligible Family Dependents by submitting to the Group the applicable enrollment form within 31 days of the date coverage under the prior plan terminated. The Group shall promptly forward to Health Plan a copy of each enrollment form received by the Group in accordance with this Section 6.2.

SECTION 7. MEMBER EFFECTIVE DATES OF COVERAGE

7.1 Effective Date

Subject to the Group's payment of the applicable total monthly premium for each Member and subject to the Group's submission to Health Plan prior to the first day of each month of a listing of each Member eligible to receive Covered Services, including all prospective Members, within thirty-one (31) days of the date of such Member's first becoming eligible, coverage under the Group Enrollment Agreement will become effective for said Members on the effective date of coverage specified by the Group.

7.2 Newborn Children

For newborn children, coverage shall become effective immediately after birth for thirty-one (31) days, and shall continue in effect thereafter only if the newborn is eligible and enrolled by the Subscriber within thirty-one (31) days following the newborn's birth.

7.3 Adopted Children

For adopted children, coverage shall become effective immediately after the child is placed in the custody of the Subscriber or the Subscriber's spouse or Domestic Partner for adoption for thirty-one (31) days, and shall continue in effect thereafter only if the child is eligible and enrolled by the Subscriber within thirty-one (31) days following the child's placement in the custody of the Subscriber or the Subscriber's spouse or Domestic Partner for adoption.

SECTION 8. PRINCIPAL BENEFITS AND COVERAGES

Members are entitled to receive the Covered Services described in this Section when such services are Medically Necessary for the treatment of a Member's Chiropractic Disorder or Acupuncture Disorder, subject to all applicable Exclusions and Limitations and Benefit Maximums, as well as all other terms and conditions contained in this Combined Evidence Of Coverage and Disclosure Form and the Group Enrollment Agreement.

8.1 Chiropractic Services Description

Chiropractic Services provided include:

(A) Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system;

(B) Initial patient examinations;

(C) Subsequent visits for further evaluation of a Member's condition;

(D) Adjunctive therapies, such as ultrasound, hot/cold packs, electrical muscle stimulation, and other therapies;

(E) Examination of any aspect of the Member's condition by means of radiological (x-ray) diagnostic imaging or clinical laboratory tests;

(F) Spinal and Extraspinal Treatment; and

(G) Durable Medical Equipment (limited to $50 per year).*

8.2 Acupuncture Services Description

Acupuncture Services provided include:

(A) Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions;

(B) Initial patient examinations;

(C) Subsequent visits for further evaluation of a Member's condition; and

(D) Adjunctive therapies such as moxibustion, cupping and acupressure.

8.3 Urgent Services

Urgent Services are services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed. Members are entitled to receive Urgent Services, including Urgent Services received outside the Health Plan's service area, when such services are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

* **Durable Medical Equipment or DME** means equipment that can withstand repeated use by Members outside a provider's office or facility, is primarily or customarily used in the treatment of Chiropractic Disorders, and is generally not useful to a Member in the absence of a Chiropractic Disorder. Members should refer to the *Schedule of Benefits* at Attachment A for a description of the DME covered under the benefit plan, and Section 9.2 for a description of the limitations applicable to DME.

8.4 Emergency Services

If a Member believes he or she requires Emergency Services as defined in Section 1.14, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Members are encouraged to use appropriately the 911 emergency response system, in areas where the system is established and operating, when they have an emergency condition that requires an emergency response.

8.5 Second Opinions

Where, as a result of a Chiropractic Disorder or Acupuncture Disorder, a treatment plan is recommended by a Participating Provider, Health Plan, Member or the treating Provider on a Member's behalf, may request that a second opinion be obtained from a Participating Provider qualified to diagnose and treat the specific Chiropractic Disorder or Acupuncture Disorder.

8.5.1 Second Opinion Requests

A Member may request a second opinion when the Member has concerns that may include, but are not be limited to, any of the following:

(A) The Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to a serious chronic condition;

(B) The Member finds that the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating chiropractic or acupuncture health professional is unable to diagnose the condition;

(C) The Member determines that the treatment plan in progress is not improving the chiropractic or acupuncture health condition of the Member within an appropriate period of time given the diagnosis and plan of care; or

(D) The Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Members may request a second opinion by contacting Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

When the request originates with the Member and concerns care from a Participating Provider, a second opinion is to be provided by any provider of the Member's choice from within the Health Plan's network. The provider must be of the same or equivalent specialty, acting within his or her scope of practice and possess clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for the second opinion.

If there is no Participating Provider within the network who meets the standard specified above, then the Health Plan shall authorize a second opinion by an appropriately qualified health professional outside of the Health Plan's provider network.

All second opinions requested or certified by Health Plan, including all related diagnostic tests, are Covered Services. If Health Plan approves a Member request for a second opinion, the Health Plan shall be responsible for the costs of such opinion. The Member shall be responsible only for the costs of applicable Copayments that the Health Plan requires for similar referrals.

If an out-of-plan second opinion is authorized by the Health Plan, the Member's Copayment will be the same as the in-network Copayment payable to the same type of provider.

A second opinion authorized by the Health Plan shall not count against the Member's benefit limitation. Unless specifically authorized by the Health Plan, any **additional** medical opinions not within the contracted network shall be the responsibility of the Member.

8.5.2 Plan Review of Requests for Second Opinions

Health Plan's authorization or denial of a request for a second opinion shall be provided in an expeditious manner. All non-urgent requests will be resolved within 72 hours of the Health Plan's receipt of a request for a second opinion.

An urgent request, when the Member's condition is such that the Member faces an imminent or serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental to the Member's ability to regain maximum function, will be expedited and resolved (authorized or denied) whenever possible within 24 hours but not to exceed 72 hours from the Plan's receipt of the request.

The Health Plan will deny a Member's request for a second opinion only in the absence of applicable benefits. In any such case, the Health Plan shall notify the Member in writing of the reasons for the denial and shall inform the Member of the right to file a grievance with the Health Plan.

A copy of the Health Plan's Policy and Procedure regarding second opinions is available to Members and the public upon request. Members may request a copy of the Policy and Procedure by contacting the Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

8.6 Continuity of Care

Upon a Member's request, Health Plan will provide for the completion of Covered Services that are being rendered by a Terminated Provider or a Non-Contracting Provider when the Member is receiving services from that provider for an "acute condition," a "serious chronic condition," or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage, or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates. Members who wish to request continuity of care coverage or a copy of Health Plan's Policy and Procedure regarding continuity of care should contact the Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*, or by writing to the Customer Services Department at the following address:

Customer Services Department
OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009

Members may also fax their questions or requests to Health Plan at (619) 641-7185, or contact Health Plan online at www.myoptumhealthphysicalhealthofca.com.

If a Member requests to keep their provider, they should include in the request the name of the provider, the provider's contact information, and information regarding the condition for which the Member is receiving care from the provider.

After Health Plan has received all information necessary, Health Plan will complete its review in a timely manner appropriate for the nature of the Member's clinical condition. Health Plan will mail the Member a written notification of its decision within five (5) business days of its decision.

Except as otherwise provided by applicable law:

8.6.1 Health Plan shall, at the request of a Member, provide for continuity of care for the Member by a Terminated Provider or by a Non-Contracting Provider who has been providing care for an acute condition, a serious chronic condition, or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates.

8.6.2 In cases involving an acute condition, Health Plan shall furnish the Member with Covered Services for the duration of the acute condition.

8.6.3 In cases involving a serious chronic condition, Health Plan shall furnish the Member with Covered Services for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Participating Provider as determined by Health Plan in consultation with the terminated provider, consistent with good professional practice.

8.6.4 In cases involving the care of a newborn child between birth and age 36 months, completion of Covered Services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.

8.6.5 The payment of any Copayments by the Member during the period of continuation of care shall be the same any Copayments that would be paid by the Member when receiving Covered Services from a Participating Provider.

8.6.6 **Definitions.** For purposes of this Section 8.6, the following definitions will apply:

8.6.6.1 **"**Acute condition" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

8.6.6.2 "Serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

8.6.6.3 **"**Provider" is an acupuncturist or chiropractor duly licensed under California law to deliver or furnish acupuncture or chiropractic services.

8.6.6.4 "Participating Provider" has the same meaning as stated in Section 1.23 of this *Combined Evidence Of Coverage and Disclosure Form*.

8.6.6.5 "Non-Contracting Provider" is a Provider who is not party to a contract with the Plan to provide acupuncture or chiropractic services.

8.6.6.6 "Terminated Provider" is a Provider whose contract with the Plan has terminated or has not been renewed.

8.6.7 **Terminated Providers.** In the event the criteria listed in the continuity of care section (8.5) are met; Health Plan will require a Terminated Provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that applied to the provider prior to termination, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Terminated Provider does not agree to comply or does not comply with these contractual terms and conditions, Health Plan will not continue the Terminated Provider's services beyond the contract termination date. In such cases, Health Plan will refer the Member to a Participating Provider.

Unless otherwise agreed by the Terminated Provider and Health Plan, the services rendered shall be compensated at rates and methods of payment similar to those used by Health Plan for Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Terminated Provider. Health Plan will not continue the services of a Terminated Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 8.6.7. In such cases, Health Plan will refer the Member to a Participating Provider.

8.6.8 **Non-Contracting Providers.** In the event the criteria listed in the continuity of care section (8.5) are met; Health Plan will allow a Non-Contracted Provider to treat a Member, as long as the provider agrees in writing to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Non-Contracting Provider, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Non-Contracting Provider does not agree to comply or does not comply with these

contractual terms and conditions, Health Plan will not continue the provider's services. In such cases, Health Plan will refer the Member to a Participating Provider.

Unless otherwise agreed upon by the Non-Contracting Provider and Health Plan, the services rendered shall be compensated at rates and methods of payment similar to those used by Health Plan for Participating Providers providing similar services who are practicing in the same or a similar geographic area as the Non-Contracting Provider. Health Plan will not continue the services of a Non-Contracted Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 8.6.8. In such cases, Health Plan will refer the Member to a Participating Provider.

8.6.9 **Limitations.** Members are not eligible to keep their provider if the provider does not agree to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as your provider. Members are not eligible to keep their provider if their provider had a contract with Health Plan which was terminated or not renewed for reasons relating to a medical disciplinary cause or reason, fraud, or other criminal activity. New Members are not eligible to keep their provider if the Member had the option to continue with another health plan or provider and voluntarily chose to change health plans. In each of these cases, Health Plan will refer the Member to a Participating Provider. Health Plan will not cover services that are not otherwise covered under a Member's benefit plan.

8.6.10 If a Member is not satisfied with Health Plan's decision, a Member may file a grievance with the Health Plan subject to the terms and instructions included at Section 15 of this *Combined Evidence Of Coverage and Disclosure Form*.

8.7 Facilities

During Health Plan's business hours (Monday through Friday, 8:30 a.m. through 5:00 p.m.) services provided through Health Plan's 24-hour toll-free telephone number referenced in Section 15.3 include referral of Members for Covered Services and responding to Member inquiries and questions regarding Covered Services. After hours, Health Plan will maintain an answering service with recorded instructions for members who call after-hours.

Health Plan: (i) maintains an after-hours answering service with recorded instructions for members who call after-hours, and (ii) requires its Participating Providers to provide Members with telephone access to a Participating Provider twenty-four (24) hours a day, seven (7) days a week**.**

Participating Providers must be available for office hours during normal business hours (generally Monday through Friday between 9:00 a.m. and 5:00 p.m.). Members may obtain office hours and emergency information from a Participating Provider's answering machine any time staff is not able to answer the phone. Members may also leave a message twenty-four (24) hours a day.

8.8 Access to Care Guidelines

Health Plan ensures that Members, during normal business hours, can speak to a customer service representative and will not have a waiting time that exceeds ten (10) minutes. Health Plan's standards for access to care from the time of the request of an appointment from a member are as follows:

Type of Care	**Timing**
Urgent Care	Within 24 hours
Routine care	Within ten (10) business days
Urgent Patient calls	Returned within 30 minutes

SECTION 9. PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

9.1 Exclusions

The following accommodations, services, supplies and other items are specifically excluded from coverage:

(A) Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;

(B) Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;

(C) Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care.

(D) Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;

(E) Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;

(F) Experimental or investigative services unless required by an external, independent review panel as described in Section 16.5;

(G) Services provided at a hospital or other facility outside of a Participating Provider's facility;

(H) Holistic or homeopathic care including drugs and ecological or environmental medicine;

(I) Services involving the use of herbs and herbal remedies;

(J) Treatment for asthma or addiction (including but not limited to smoking cessation);

(K) Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;

(L) Transportation to and from a provider;

(M) Drugs or medicines;

(N) Intravenous injections or solutions;

(O) Charges for services provided by a Provider to his or her family Member(s);

(P) Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;

(Q) Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;

(R) Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;

(S) Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services Urgent Services, or other services authorized by Health Plan;

(T) Ambulance services;

(U) Surgical services;

(V) Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder or Acupuncture Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;

(W) Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child;

(X) Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Medical Emergencies are covered by the Member's medical plan rather than OptumHealth Physical Health of California

9.2 Limitations

The *Schedule of Benefits* attached as Attachment A lists the Copayments and Annual Benefit Maximums that are applicable to, and that operate as Limitations on, Covered Services. Coverage for Durable Medical Equipment is limited to $50 per year.

SECTION 10. CHOICE OF PROVIDERS

10.1 Access to Participating Provider

Each Member who requests that Covered Services be provided will be able to choose from any Health Plan Participating Provider who will coordinate the Covered Services to be received by the Member. Members may request access to a Participating Provider by contacting Health Plan's Customer Services department at the toll-free telephone number printed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

10.2 Liability of Member for Payment

If a Member chooses to obtain out-of-network Chiropractic Services or Acupuncture Services (other than Urgent Services) from a provider other than a Participating Provider, the Member will be liable for payment for such services. **Services (other than Urgent Services) performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child are not covered.**

SECTION 11. COORDINATION OF BENEFITS (COB)

11.1 The Purpose of COB

The provisions of this Section establish a procedure through which Health Plan or a Participating Provider may, in certain instances, recover a portion of the costs of Covered Services from an insurer or other third-party payor which also provides indemnity or other coverage for Chiropractic Services or Acupuncture Services provided to a Member. The Group and all Members shall cooperate with Health Plan in the administration of these provisions.

11.2 Benefits Subject to COB

All of the benefits provided under this Agreement are subject to COB in accordance with the provisions of this Section 11.

11.3 Definitions

The following definitions are applicable to the provisions of this Section only:

11.3.1 "Plan" means any plan providing chiropractic and acupuncture benefits for, or by reason of, Chiropractic Services and Acupuncture Services, which benefits are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs other than Medi-Cal, or California Children's Services, and any coverage required or provided by any statute.

11.3.2 The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

11.3.2.1 The term "Plan" shall include:

11.3.2.1.1 All group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to Section 10270.97 of the California Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to 10270.2(b) or (e) which contain non-duplication of benefits or excess policy provisions.

11.3.2.1.2 "Medicare" or other similar governmental benefits, provided that:

(A) The definition of "Allowable Expenses" shall only include the chiropractic and acupuncture benefits as may be provided by the governmental program;

(B) Such benefits are not by law excess to this Plan; and

(C) The inclusion of such benefits is inconsistent with any other provision of this Agreement.

11.3.2.1.3 The term "Plan" shall not include:

11.3.2.1.3.1 Individual or family policies, or individual or family subscriber contracts, except as otherwise provided herein.

11.3.2.1.3.2 Any entitlements to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the California Welfare and Institutions Code, or benefits under the California Children's Services under Section 10020 of the Welfare and Institutions Code, or any other coverage

provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.

11.3.2.1.3.3 Medical payment benefits customarily included in traditional automobile contracts.

11.3.3 "Plan" means that portion of this Agreement that provides the benefits that are subject to this Section.

11.3.4 "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and benefit paid.

11.3.5 "Claim Determination Period" means a calendar year.

11.4 Effect on Benefits

11.4.1 This Section 11 shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:

11.4.1.1 The value of the benefits that would be provided by this Plan in the absence of this Section 11, and

11.4.1.2 The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

11.4.2 As to any Claim Determination Period to which this Section is applicable, the benefits that would be provided under this Plan in the absence of this provision for Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in Section 11.4.3 immediately below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefore.

11.4.3 If another Plan which is involved in Section 11.4.2 immediately above and which contains: provisions coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and the rules set forth in Section 11.5 immediately below would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

11.5 Rules Establishing Order of Determination

For the purpose of Section 11.4, the rules establishing the order of determination are:

11.5.1 The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as dependent.

11.5.2 Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of the benefits.

11.5.3 In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

11.5.4 In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as dependent of the parent without custody.

11.5.5 In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced where there is a court decree which would otherwise establish financial responsibility for the costs of Chiropractic Services or Acupuncture Services with respect to the child, then, notwithstanding Sections 11.5.3 and 11.5.4, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

11.5.6 When Sections 11.5.1 through 11.5.5 do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

11.5.6.1 The benefits of a Plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

11.5.6.2 If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining benefits after the other, then Section 11.5.6.1 shall not apply.

In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this provision.

If a claimant's effective date of coverage under a given Plan is subsequent to the date the other carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this provision, that the claimant's length of time covered under the Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his or her coverage under that Plan has been in force.

11.6 Reduction of Benefits

When this Section 11 operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan. Health

Plan may not decrease, in any manner, the benefits stated herein, except after a period of at least thirty (30) days from the date of the postage paid mailing to the Group.

11.7 Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section 11 of this Plan or any provision of similar purpose of any other Plan, to the extent permitted by applicable law, including the Health Insurance Portability and Accountability Act of 1996 and the Confidentiality of Medical Information Act, the Plan may release to or obtain from any insurance Health Plan or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

11.8 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

11.9 Right of Recovery

Whenever payments have been made by the Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Section 11, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to, for, or with respect to whom such payments were made, any insurers, any service plans, or any other organizations.

SECTION 12. THIRD-PARTY LIABILITY

12.1 Member Reimbursement Obligation

If a Member receives payment by way of a third-party suit or settlement for Covered Services provided or paid for by Health Plan, the Member shall be obligated to reimburse Health Plan for the actual costs incurred by Health Plan for such Covered Services, but no more than the amount the Member recovers on account of the condition for which Covered Services were provided, exclusive of any amounts awarded in a suit as compensatory damages for any items other than the expenses of Chiropractic Services and Acupuncture Services and any amounts awarded as punitive damages.

12.2 Health Plan's Right of Recovery

Health Plan shall have a lien on all funds recovered by a Member from a third party pursuant to Section 12.1 immediately above. Such lien shall not exceed the sum of the reasonable costs actually paid by Health Plan to perfect the lien and the amount actually paid by Health Plan to any treating provider. If the Member engaged an attorney, the lien may not exceed one-third (1/3) of the monies due to the Member under any final judgment, compromise, or settlement agreement. If the Member did not engage an attorney, the lien may not exceed one-half (1/2) of the monies due to the Member under any final judgment, compromise, or settlement agreement. Health Plan may give notice of such lien to any party who may have contributed to the loss.

12.3 Member Cooperation

The Member shall take such action, furnish such information (including responding to requests for information about any accident or injuries and making court appearances) and assistance, and execute such instruments (including a written confirmation of assignment, and consent to release medical records) as Health Plan may require to facilitate enforcement of Health Plan's rights under this Section 12, and shall take no action that tends to prejudice such rights. Any Member who fails to cooperate in Health Plan's administration of this Section 12 shall be responsible for the amount otherwise recoverable by Health Plan under this Section.

12.4 Subrogation Limitation

Health Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, from any or all of the following:

(A) Third parties, including any person alleged to have caused Member to suffer injuries or damages;

(B) Member's employer;

(C) Any person or entity obligated to provide benefits or payments to Member, including benefits or payments for underinsured or uninsured motorist protection (collectively referred to as "Third Parties.")

Health Plan has the right to be subrogated to the Member's rights for all amounts recoverable by Health Plan under this Section 12. Health Plan's rights under this Section 12.4 include the right to bring suit against the third party in the Member's name.

Member agrees:

(A) To assign all rights of recovery against Third Parties, to the extent of the actual costs of Covered Services provided or paid for by Health Plan, plus reasonable costs of collection;

(B) To cooperate with Health Plan in protecting Health Plan's legal rights to subrogation and reimbursement;

(C) That Health Plan's rights will be considered as the first priority claim against Third Parties, to be paid before any other of Member's claims are paid;

(D) That Member will do nothing to prejudice Health Plan's rights under this provision, either before or after the need for services or benefits under this document;

(E) That Health Plan may, at Health Plan's option, take necessary and appropriate action to preserve Health Plan's rights under these subrogation provisions, including filing suit in Member's name;

(F) That regardless of whether or not Member has been fully compensated, Health Plan may collect from the proceeds of any full or partial recovery that Member or Member's legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the actual costs incurred by Health Plan for Covered Services provided or paid for by Health Plan;

(G) To hold in trust for Health Plan's benefit under these subrogation provisions any proceeds of settlement or judgment;

(H) That Health Plan shall be entitled to recover from Member reasonable attorney fees incurred in collecting proceeds held by Member;

(I) That Member will not accept any settlement that does not fully compensate or reimburse Health Plan without Health Plan's written approval.

SECTION 13. MANAGED CARE PROGRAM

13.1 Managed Care Program

The Managed Care Program is the program by which Health Plan determines whether services or other items are Medically Necessary and directs care in the most cost-efficient manner. The Managed Care Program includes, but is not limited to, requirements with respect to the following: concurrent and retrospective utilization review; and quality assurance activities. The Managed Care Program requires the cooperation of Members, Participating Providers, and Health Plan. All Participating Providers have agreed to participate in Health Plan's Managed Care Program.

13.2 Managed Care Process

Health Plan's Utilization Management Committees will have program oversight for Chiropractic Services and Acupuncture Services provided, or to be provided, to Members under this Agreement in order to determine: (i) whether the services are/were Medically Necessary; (ii) the appropriateness of the recommended treatment setting; (iii) the required duration of treatment; (iv) whether the recommended treatment qualifies as a Covered Service; and (v) whether any Limitations apply.

13.3 Appeal Rights

All decisions made by Health Plan in connection with the Managed Care Program may be appealed by the Member through the Grievance Procedure set forth in Section 16.

13.4 Utilization Management

Health Plan utilizes the following process to authorize, modify, or deny services under benefits provided by the Health Plan.

13.4.1 **Utilization Review**. Utilization review occurs as the services are provided (concurrent), or after the services have been provided (retrospective). The Utilization Review Process requires health care providers to submit the authorization request forms. Utilization review will not be conducted more frequently than is reasonably required to assess whether the health care services under review meet plan benefit coverage criteria. The provider is responsible for documenting the medical necessity of services through the authorization process.

13.4.2 **Benefit Coverage Determinations.** Benefit coverage determinations are made by the Health Plan's Support Clinicians based upon your benefit plan and may include an adverse determination due to a limitation in benefit coverage or an exclusion of benefit coverage. These are not medical necessity determinations.

13.4.3 **Support Clinicians/Clinical Peer Reviewers.** All clinical reviews are conducted by licensed peer reviewers who meet the Health Plan provider credentialing process and possess the additional qualifications.

13.4.4 **Member Disclosure**. The process used by Health Plan to authorize, modify, or deny health care services under any benefit plan will be disclosed to members or their designees upon request.

13.4.5 **Notifications and Time Frames.** Unless specific state or federal law requires other time frame and notification standards, the following will apply for Health Plan's utilization management determinations.

13.4.5.1 Health Plan uses one standard process that applies to both concurrent and retrospective review. The Support Clinician completes the concurrent review process within five (5) business days of receipt of all necessary information. Retrospective reviews are completed within thirty (30) business days of receipt of all necessary information.

13.4.5.2 An Authorization Response is sent to the provider and Enrollee indicating the Support Clinician's decision within one (1) business day of the date of decision. The written response is sent to the provider by U.S. Mail. Written notification is sent to the Enrollee by U.S. Mail.

13.4.5.3 The Authorization Response sent to the provider and the Enrollee includes messages addressing any changes to the requested treatment plan. In addition, each response to the provider includes

the name of the Support Clinician and instructions and timelines for the submission of missing or additional documentation.

13.4.5.4 If Health Plan cannot make a decision to approve, modify or deny a request for authorization within the time frames specified above because Health Plan is not in receipt of all of the information reasonably necessary and requested, or because Health Plan requires consultation by an expert reviewer, or because Health Plan has asked that an additional examination or test be performed upon the member (provided the examination or test is reasonable and consistent with good medical practice in the organized chiropractic community), Health Plan shall, immediately upon the expiration of the specified time frame, or as soon as Health Plan becomes aware that it will not meet the time frame, whichever occurs first, notify the provider and the member, in writing, that Health Plan cannot make a decision to approve, modify, or deny the request for authorization within the required time frame, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. Health Plan shall also notify the provider and the member of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested, Health Plan will approve, modify, or deny the request for authorization within the applicable time frame specified above.

13.4.5.5 A request for services may be denied on the basis that information necessary to determine medical necessity was not received. If Health Plan requests medical information from a provider in order to determine whether to approve, modify, or deny a request for authorization, Health Plan will request only the information reasonably necessary to make the determination. A reasonable attempt to obtain the missing information from the enrollee's provider will be made prior to denying services based on lack of information. The request for the necessary information will be handled in accordance with Health Plan policy.

13.4.5.6 In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of Health Plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member.

13.4.6 Adverse Determinations. Unless specific state or federal law requires other time frame and notification standards, the following will apply for Health Plan's utilization management determinations.

13.4.6.1 An adverse determination by a Health Plan Support Clinician means one or more of the service(s) requested was determined to be not Medically Necessary or appropriate.

13.4.6.2 Clinical determinations are decisions made with regard to the provider's requested duration of care, quantity or services or types of services.

13.4.7 Nothing in this Section 13 shall be construed or applied to interfere with a Member's right to submit a grievance or seek an independent medical review in accordance with applicable law. Members shall in all cases have an opportunity to submit a grievance to Health Plan or seek an independent medical review whenever a health care service is denied, modified, or delayed by Health Plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not Medically Necessary.

13.4.8 All grievances shall be handled in accordance with Health Plan's Grievance Resolution Policies and Procedures, as described in Section 16.

13.4.9 A request for an independent medical review shall be handled in accordance with Health Plan's policies and procedures on independent medical reviews or, if applicable, the policies and procedures on independent review of decisions regarding experimental or investigational therapies, as described in Section 16.5.

SECTION 14. REIMBURSEMENT PROVISIONS

Members may receive Covered Services under the Group Enrollment Agreement only from Participating Providers or as directed by the Health Plan. Claims for reimbursement for Covered Services received by a Member shall be submitted by the Participating Provider. The Member shall not be responsible for submitting claim forms for reimbursement of any Covered Services.

SECTION 15. RESPONSIBILITIES OF HEALTH PLAN

15.1 Arrangements for Covered Services

Health Plan will enter into arrangements with Participating Providers in order to make available to Members the Covered Services described in this document. Subject to Section 8.6, Health Plan makes no warranty or representation to the Group or to Members regarding the continued availability of any particular Participating Provider to a particular Member or to Members in general.

15.2 Compensation of Providers

Health Plan will be responsible for compensating Participating Providers for Covered Services provided to eligible Members in accordance with the requirements of any contract between Health Plan and the Participating Provider. As required by state law, all contracts between Health Plan and Participating Providers provide that, in the event Health Plan fails to pay the Participating Provider for Covered Services for which Health Plan is financially responsible, no Member shall be liable to the Participating Provider for Covered Services.

In the event that Health Plan fails to pay a provider who is not a Participating Provider for Covered Services for which Health Plan is financially responsible, the Member who received such services may be liable to the provider for the cost of the services.

15.3 Toll-Free Telephone Number

Health Plan will make available to Members a published toll-free telephone number to contact Health Plan. This telephone number is available to Members twenty-four hours a day, seven days a week.

15.4 Public Policy Committee

Health Plan's Public Policy Committee will participate in establishing public policy for Health Plan's chiropractic and acupuncture benefits programs including, but not limited to, the comfort, dignity and convenience of Members. Members are invited to participate in the Public Policy Committee and may write to the Chair of the Public Policy Committee at the address included on the cover of this document.

15.5 Notices to Group Representatives

Any notice given by Health Plan to the Group pursuant to the Group Enrollment Agreement may be given by Health Plan to the group representative designated by the Group pursuant to this Section 15.5.

15.6 Termination or Breach of a Participating Provider Contract

15.6.1 Health Plan shall provide Group written notice within 30 days of Health Plan's receipt of any Participating Provider's notice of termination or inability to perform its contract with Health Plan, or within 30 days of Health Plan's providing to any Participating Provider a notice of termination or uncured breach, if the Group or any Member may be materially and adversely affected by such termination, breach, or inability to perform.

15.6.2 In the event that a contract between Health Plan and a Participating Provider terminates while a Member is under the care of such Participating Provider, Health Plan will arrange for the provision of continuity of care services as described in Section 8.6.

15.6.3 In the event that Health Plan fails to pay a non-contracting provider for any amounts owed by the Health Plan, Member may be responsible to the non-contacting provider for the cost of services.

SECTION 16. GRIEVANCE PROCEDURES

16.1 Applicability of the Grievance Procedures

All Member disputes and controversies arising under the Plan will be resolved pursuant to the Grievance Procedures set forth in this Section 16.

16.2 Grievances

Every Member has the right to communicate a grievance to Health Plan by calling the telephone number listed below, by submitting a written grievance to the address indicated below, by submitting a written grievance by facsimile or email, or by completing an online grievance form.

Grievance Coordinator
OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009
1-800-428-6337
(619) 641-7185 (Fax)
www.myoptumhealthphysicalhealthofca.com

Health Plan will acknowledge receipt of the grievance in writing for urgent issues on the day of receipt, and all routine grievances within five (5) calendar days of receipt. These deadlines do not apply to grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day.

If the grievance pertains to a Quality of Service issue, it may be investigated and resolved by the Health Plan in collaboration with any other involved departments. If the grievance pertains to a Quality of Care issue and is routine, the Health Plan transfers the information to the Medical Director. If the grievance pertains to a Quality of Care issue and is urgent, the Health Plan will promptly initiate the Expedited Review process.

Health Plan will provide a written statement on the determination of any grievance except for grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day. For an urgent grievance in which medical/clinical services are underway, Health Plan will notify the complainant and the Department within twenty-four (24) hours of the Health Plan's receipt of the grievance. For all other urgent grievances, Health Plan will notify the complainant and the Department within three (3) calendar days of the Health Plan's receipt of the grievance. For routine grievances, Health Plan will notify the complainant within five (5) calendar days of the Health Plan's receipt of the grievance.

Grievance forms and Health Plan’s grievance policies and procedures are available to Members upon request.

16.3 Expedited Review of Grievances

For Member grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, Health Plan shall immediately inform the Member, in writing, of the Member's right to notify the Department, and to provide the Member and the Department written notice of the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the grievances.

16.4 Independent Medical Review

In the event the Member is dissatisfied with the findings and decision of Health Plan, the Member is not required to further participate in Health Plan’s grievance process thirty (30) days after Health Plan’s receipt of the complaint. The Member may request an Independent Medical Review (IMR) of Disputed Health Care Services from the Department if the Member believes that health care services have been improperly denied, modified, or delayed by the Health Plan or one of its contracting providers. A “Disputed Health Care Service” is any health care service eligible for coverage and payment under

the subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to the Member. The Member pays no application or processing fees of any kind for IMR. The Member has the right to provide information in support of the request for IMR. The Plan must provide the Member with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against the plan regarding the Disputed Health Care Service.

For more information regarding the IMR process, or to request an application form, please call Health Plan's Customer Services department at 1-800-428-6337; or write to OptumHealth Physical Health of California at P.O. Box 880009, San Diego, CA
92168-0009.

16.5 IMR for Experimental and Investigational Therapies

You may also have the right to an independent medical review through the Department if the Health Plan denies coverage for a requested service on the basis that it is experimental or investigational. Health Plan will notify you within 5 business days of its decision to deny an experimental/investigational therapy. You are not required to participate in the Health Plan's grievance process prior to seeking an independent medical review of this decision.

The Independent Medical Review Organization will complete its review within 30 days of receipt of your application and supporting documentation. If your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the review will be completed within 7 days.

16.6 Implementation of IMR Decision

If the Member receives a decision by the Director of the Department that a Disputed Health Care Service is Medically Necessary, Health Plan will promptly implement the decision.

In the case of reimbursement for services already provided, Health Plan will reimburse the provider or Member within five (5) working days. In the case of services not yet provided, Health Plan will authorize the services within five (5) working days of receipt of the written decision from the Director or sooner, if appropriate for the nature of the Member's medical condition, and will inform the Member and Provider of the authorization according to the requirements of Health and Safety Code Section 1367.01(h)(3).

16.7 Exhaustion of Remedies

A Member shall not be entitled to maintain a cause of action alleging that Health Plan has failed to exercise ordinary care unless the Member or his or her representative has exhausted the procedures provided by IMR process, except in a case where either of the following applies: (i) substantial harm has occurred prior to the completion of the IMR process; or (ii) substantial harm will imminently occur prior to the completion of the IMR process. For purposes of this Section 16.7, substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.

16.8 Department Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-800-428-6337) or (1-619-641-7100) or for TTY/TDD services call 1-(888) 877-5379 (voice), or 1-(888) 877-5378 (TDDY)) and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment

disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) or (1-800-735-2929) for the hearing- and speech-impaired. The Department's Internet website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

SECTION 17. TERMINATION OF BENEFITS

17.1 Basis for Termination of a Member's Coverage

Health Plan may terminate a Member's coverage for any one or more of the following reasons:

17.1.1 If the Group has failed to pay a premium due within 31 days of the Premium Due Date, Health Plan shall send a notice of cancellation to the Group requesting payment of any past due premiums and providing notice that coverage for a Member whose premium is unpaid shall terminate automatically as of the sixteenth (16th) day following issuance of such notice of cancellation. If the Member is hospitalized or undergoing treatment for an ongoing condition at the time of such termination, Health Plan shall continue to be financially responsible only for those Chiropractic Services and Acupuncture Services provided after such termination that had already received prior written certification as Covered Services, and had already commenced, as of the date of such termination.

17.1.2 The Member fails to pay or make appropriate arrangements to pay a required Copayment after the Member has been billed by the provider for two different billing cycles. Health Plan will provide the Member with written notice, and the Member will be subject to termination if payment or appropriate payment arrangements are not made within the thirty (30)-day notice period.

17.1.3 If the Member permits the misuse of his or her identification documents by any other person, or misuses another person's identification, coverage of the Member may be terminated immediately upon notice to the Member. The Member shall be liable to Health Plan for all costs incurred as a result of any misuse of identification documents.

17.1.4 A Member's coverage will be terminated upon mailing of notice if a Member threatens the safety of any provider, his or her office staff, or the Health Plan if such behavior does not arise from a diagnosed illness or condition. In addition, a Member's coverage may be immediately terminated upon mailing of notice if the Member repeatedly or materially disrupt the operations of the Health Plan to the extent that the Member's behavior substantially impairs Health Plan's ability to furnish or arrange services for the Member or other Members or substantially impairs the ability of any provider, or his or her office staff, to provide services to other patients.

17.1.5 The Member moves out of the service area without the intention to return. Termination shall be effective on the sixteenth (16th) day following issuance of such notice.

17.1.6 The Member voluntarily disenrolls, provided the Group allows voluntary disenrollment. Termination shall take effect on the last day of the month in which the Member voluntarily disenrolls.

17.1.7 The notice of cancellation issued by Health Plan shall be in writing and dated, and shall state:

(A) The cause for cancellation, with specific reference to the clause of this Agreement giving rise to the right of cancellation;

(B) That the cause for cancellation was not the Member's health status or requirements for health care services;

(C) The time when the cancellation is effective; and

(D) That a Member who alleges that an enrollment or subscription has been cancelled or not renewed because of the Member's health status or requirements for health care services may request a review of cancellation by the Director of the Department.

17.2 Reinstatement

Subject to Section 17.5, the reinstatement of any Member whose coverage under this Agreement has terminated for any reason shall be within the sole discretion of Health Plan. This Section does not apply to reinstatement of the Group, but

rather to reinstatement of a Member whose coverage has terminated for reasons unrelated to cancellation of the Group Enrollment Agreement for nonpayment.

17.3 Rescission

If, at any time, Health Plan determines that a Member fraudulently or intentionally provided incomplete or incorrect material information and Health Plan's decision to accept the Member's enrollment was based, in whole or in part, on the misinformation, Health Plan may rescind the Member's membership instead of terminating the Member's coverage upon the date of mailing. Rescind means Health Plan will completely cancel membership so that no coverage ever existed. Health Plan can also rescind membership if it finds that a Member fraudulently or intentionally did not inform Health Plan about changes to the information the Member submitted in their enrollment application that occurred before the Member's coverage became effective, and Health Plan would have denied the Member's enrollment if the Member had informed Health Plan about the changes. If Health Plan rescinds a membership, Health Plan will send written notice to the affected Member which will explain the basis for Health Plan's decision and how the Member may appeal the decision. Any Member whose membership is rescinded will be required to pay as a non-Member for any services Health Plan covered. Within 30 days, Health Plan will refund all applicable premiums amounts due pursuant to Section 17.4, except that Health may subtract any amounts the Member owes Health Plan. The Member will not be allowed to enroll in an OptumHealth Physical Health of California health plan in the future.

17.4 Return of Premiums for Unexpired Period

In the event of termination or rescission of a Member's coverage by Health Plan, Health Plan shall, within thirty (30) days following such termination, return to the Group the pro rata portion of any premium paid to Health Plan that corresponds to any unexpired period for which payment had been made less any amounts due to Health Plan from the Group.

17.5 Director Review of Termination

Any Member who in good faith believes that his or her coverage has been terminated or not renewed because of the Member's health status or requirements for Chiropractic Services or Acupuncture Services, may request a review of the termination or non-renewal by the Director of the California Department of Managed Health Care. If the Director determines that a proper complaint exists under Section 1365 of the California Health and Safety Code, the Director will notify Health Plan of that fact. Health Plan must, within fifteen (15) days after receipt of the notice, either request a hearing or reinstate the Member. If, based on the hearing, the Director determines that the termination or non-renewal is contrary to applicable law; Health Plan must reinstate the Member retroactive to the time of the termination or non-renewal. Under such circumstances, Health Plan will be liable for the expenses incurred by the Member after the termination or non-renewal for Chiropractic Services or Acupuncture Services that would otherwise have received certification as Covered Services.

17.6 Individual Continuation of Benefits

In the event the Group ceases to exist, the Group contract is terminated, an individual Subscriber leaves the Group or the Member's eligibility status changes, the Member may remain in the Plan if he or she otherwise satisfies the eligibility criteria for COBRA.

17.6.1 Continuation of Benefits for Totally Disabled Members

If a Member becomes Totally Disabled while covered under the Group Enrollment Agreement, and the Group Enrollment Agreement between Health Plan and the Group is subsequently terminated, benefits for Covered Services directly relating to the disabling condition will continue for twelve (12) months following the last day of coverage for which a total monthly premium was paid to Health Plan on behalf of the Member, notwithstanding the termination of the Group Enrollment Agreement during such period. Any extension of benefits may be terminated at such time as the Member is no longer totally disabled or at such time as coverage for the Member becomes effective under any replacement agreement or policy. Covered Services provided after termination will be subject to all of the Exclusions and Limitations, as well as all of the other terms and conditions, contained in this document, including, but not limited to, all applicable Copayments and Annual Benefit Maximums. A Member who is not a Family Dependent will be considered to be Totally Disabled when as a result of bodily injury or disease, he or she is prevented from engaging in any

occupation for compensation or profit; a Member who is a Family Dependent will be considered totally disabled when such Member is prevented from performing all regular and customary activities usual for a person of his or her age and family status. An enrolled Family Dependents who attain the limiting age may continue enrollment in the Health Plan beyond the limiting age if the Family Dependent meets all of the following:

1. The Family Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. The Family Dependent is chiefly dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Family Dependent reaching the limiting age, you, the Subscriber will receive notice that coverage for the disabled Family Dependent, will terminate at the end of the limiting age unless proof of such incapacity and dependency is provided to Health Plan by the Member within 60 days of receipt of notice. Health Plan shall determine if the disabled Family Dependent meets the conditions above, prior to the disabled Family Dependent reaching the limiting age. Otherwise, coverage will continue until Health Plan makes a determination.

Health Plan may require ongoing proof of a Family Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Family Dependent's attainment of the limiting age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other physician to the effect that such disabled Family Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, Health Plan may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide Health Plan with the requested information within 60 days of receipt of the request. The child must have been covered as a dependent of the Subscriber or spouse under a previous health plan at the time the child reached the age limit.

17.6.2 Continuation of Coverage under Federal Law

If Member's coverage ends, Member may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law. Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Groups that are subject to the terms of COBRA. Member can contact his or her plan administrator to determine if the Group is subject to the provisions of COBRA. If Member selected continuation coverage under a prior plan which was then replaced by coverage under this plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier. Health Plan is not the Group's designated "plan administrator" as that term is used in federal law and does not assume any responsibilities of a "plan administrator" according to federal law.

Health Plan is not obligated to provide continuation coverage to Member if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are: (A) Notifying Member in a timely manner of the right to elect continuation coverage; and (B) Notifying Health Plan in a timely manner of your election of continuation coverage.

17.6.3 Qualified Beneficiary

In order to be eligible for continuation coverage under federal law, Member must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who was covered under the plan on the day before a qualifying event:

(A) A Subscriber.

(B) A Subscriber's Family Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

(C) A Subscriber's former spouse.

17.6.3.1 Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

(A) Termination of the Subscriber from employment with the Group, for any reason other than gross misconduct, or reduction of hours; or

(B) Death of the Subscriber;

(C) Divorce or legal separation of the Subscriber;

(D) Loss of eligibility by a Family Dependent who is a child;

(E) Entitlement of the Subscriber to Medicare benefits; or

(F) The Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Family Dependents. This is also a qualifying event for any retired Subscriber and his or her Family Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

17.6.4 Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or a Family Dependent's loss of eligibility as a Family Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period, the Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Group's designated plan administrator. If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

17.6.5 Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under this document will end on the earliest of the following dates:

(A) Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A). If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A, then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to

the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

(B) Thirty-six months from the date of the qualifying event for a Family Dependent whose coverage ended because of the death of the Member, divorce or legal separation of the Subscriber, loss of eligibility by a Family Dependent who is a child (i.e., qualifying events B, C, or D).

(C) For the Family Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

(D) The date coverage terminates under the plan for failure to make timely payment of the Premium.

(E) The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

(F) The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Group filed for bankruptcy, (i.e., qualifying event F)

(G) The date this document terminates.

(H) The date coverage would otherwise terminate under this document.

17.6.5 CAL-COBRA.

Group with two (2) to nineteen (19) subscribers who do not qualify for federal COBRA, continuation coverage under this Health Plan shall comply with the requirements of the California Continuation Benefits Replacement Act, as amended ("Cal-COBRA"). Continuation coverage under Cal-COBRA shall be provided in accordance with section 1366.20 et seq. of the California Health and Safety Code, and shall be equal to, and subject to the same limitations as, the benefits provided to other Group Members regularly enrolled in this Health Plan. Group shall provide affected Members with written notice of available continuation coverage as required by, and in accordance with, Cal-COBRA and amendments thereto.

17.6.5.1 Notice Upon Termination.

Upon the termination of continuation coverage under Cal-COBRA, Group shall notify affected Members receiving Cal-COBRA continuation coverage whose continuation coverage will terminate under Health Plan prior to the end of statutory continuation coverage period of the Member's ability to continue coverage under a new group plan for the balance of the statutory period. Notice shall be provided 30 days prior to the termination or when all Members are notified, whichever is later Group shall notify a successor plan in writing of the Members receiving Cal-COBRA continuation coverage.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Group filed for bankruptcy, (i.e., qualifying event F) and the retired Subscriber dies during

the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Group's designated plan administrator for information regarding the continuation period.

SECTION 18. GENERAL INFORMATION

18.1 Relationship Between Health Plan and Each Participating Provider

The relationship between Health Plan and each Participating Provider is an independent contractor relationship. Participating Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an employee or agent of any Participating Provider. Health Plan will not be liable for any claims or demands on account of damages arising out of, or in any manner connected with, any injury suffered by a Member relating to Chiropractic Services or Acupuncture Services received by the Member from any Participating Provider.

18.2 Members Bound by the Group Enrollment Agreement

By the Group Enrollment Agreement, the Group makes coverage under Health Plan's chiropractic and acupuncture benefits program available to Members who are eligible and duly enrolled in accordance with the requirements of the Group Enrollment Agreement. The Group Enrollment Agreement is subject to amendment and termination in accordance with its terms without the necessity of either Health Plan or the Group obtaining the consent or concurrence of any Member. By electing coverage or accepting benefits under the Group Enrollment Agreement, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to be bound by all of the terms and conditions of the Group Enrollment Agreement. In the case of conflicts between the Group Enrollment Agreement and this *Combined Evidence Of Coverage and Disclosure Form*, the provisions of this *Combined Evidence Of Coverage and Disclosure Form* shall be binding upon Health Plan notwithstanding any provisions of the Group Agreement that may be less favorable to Members.

18.3 Nondisclosure and Confidentiality

Neither Health Plan nor the Group shall release any information regarding the terms set forth in this Agreement to any person or entity without the prior written consent of the other, except such information as may be necessary to disclose to agents, affiliates, attorneys, accountants, governmental regulatory agencies, non-covered custodial parents of a covered children, or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law or provisions of the Agreement, Health Plan and the Group shall keep confidential, and shall take the usual precautions to prevent the unauthorized disclosure of any and all resources required to be prepared or maintained in accordance with this Agreement.

18.4 Overpayments

Member shall agree to reimburse Health Plan, on demand, any and all such amounts Health Plan pays to or on behalf of a Member:

(A) For services or accommodations which do not qualify as Covered Services;

(B) With respect to a Subscriber's family member or a person believed to be a Subscriber's family member, who is not entitled to Covered Services under the Group Enrollment Agreement; or

(C) Which exceeds the amounts to which the Member is entitled under the Group Enrollment Agreement.

18.5 Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

18.6 Interpretation of Benefits

Subject to the Member grievance procedures specified in Section 16, Health Plan has the sole and exclusive discretion to do all of the following:

(A) Interpret benefits under the plan.

(B) Interpret the other terms, conditions, limitations and exclusions set out in the plan, including this document and any Amendments.

(C) Make factual determinations related to this document and benefits.

Health Plan may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the plan.

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

18.7 Administrative Services

Health Plan may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Health Plan's sole discretion. Health Plan is not required to give Member prior notice of any such change, nor is Health Plan required to obtain Member's approval. Member must cooperate with those persons or entities in the performance of their responsibilities.

18.8 Amendments to the Plan

To the extent permitted by law, Health Plan reserves the right, in Health Plan's sole discretion and without Member's approval, to change, interpret, modify, withdraw or add benefits or terminate this document. Any provision of this document which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations, (of the jurisdiction in which this document is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to this document unless it is made by an Amendment, which has been signed by one of Health Plan's officers. All of the following conditions apply:

(A) Amendments to this document are effective 31 days after Health Plan sends written notice to the Group.

(B) Riders are effective on the date Health Plan specifies.

(C) No agent has the authority to change this document or to waive any of its provisions.

(D) No one has authority to make any oral changes or amendments to this document.

18.9 Clerical Error

If a clerical error or other mistake occurs, that error will not deprive Member of benefits under this document, nor will it create a right to benefits. If the Group makes a clerical error (including, but not limited to, sending Health Plan inaccurate information regarding Member's enrollment for coverage or the termination of Member's coverage under the this document) Health Plan will not make retroactive adjustments beyond a 60-day time period.

18.10 Information and Records

At times, Health Plan may need additional information from Member. Member agrees to furnish Health Plan with all information and proofs that Health Plan may reasonably require regarding any matters pertaining to this document. If Member does not provide this information when Health Plan requests it, Health Plan may delay or deny payment of Member's benefits. By accepting benefits under this document, Member authorizes and directs any person or institution that has provided services to Member to furnish Health Plan with all information or copies of records relating to the services provided to Member. Health Plan has the right to request this information at any reasonable time. Health Plan agrees that such information and records will be considered confidential. Health Plan has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this document, for appropriate medical review or quality assessment, or as Health Plan is required to do by law or regulation. During and after the term of this document, Health Plan and our related entities may use and transfer the information gathered under this document in a de-identified format for commercial purposes, including research and analytic purposes. For complete listings of your medical records or billing statements Health Plan recommends that Member contact his or her health care provider. Providers may charge Member reasonable fees to cover their costs for providing records or completing requested forms. If Member requests forms or records from us, Health Plan also may charge Member reasonable fees to cover costs for completing the forms or providing the records. In some cases, Health Plan will designate other persons or entities to request

records or information from or related to Member, and to release those records as necessary. Health Plan's designees have the same rights to this information as Health Plan has.

18.11 Preventive Health Information

Health Plan has preventive health information on its websites, **www.myoptumhealthphysicalhealthofca.com** and **www.myoptumhealth.com**. The information is presented to educate members on prevention of musculoskeletal injuries or conditions. The information is not intended to replace the advice received from your medical care provider. Any information taken from the website should be discussed with your medical provider to determine whether it is appropriate for your condition.

Website Address:
http://www.myoptumhealthphysicalhealthofca.com

Customer Service:
1-800-624-8822
771 (TTY)
www.uhcwest.com

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