UHC OF CALIFORNIA dba UNITEDHEALTHCARE OF CALIFORNIA
MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT
COVER SHEET
(This Cover Sheet is an integral part of this Agreement)

GROUP NAME: SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP

GROUP CODE: Please see attached Reference Page

GROUP COVERAGE EFFECTIVE DATE: January 1, 2021 through December 31, 2021

PLAN CODE: WUN/WUP/WUZ, P2A, IZY, BDX, 397, R1A

PLAN DESCRIPTION: SignatureValue (HMO) 30/750A Santa Clara County Schools Insurance Group Plan with Custom Acupuncture/Chiropractic $15/40 Visits, Custom Infertility Basic Diagnosis and Treatment, UnitedHealthcare of California Behavioral Health SV&SVA SMI + BH Buy-Up Rider, Custom Managed Formulary $10 Generic / $25 Brand / $40 Non-Formulary Rx - $40SI/$1.5K Outpatient Prescription Drugs and Real Appeal Rider

HEALTH PLAN PREMIUMS: Please see attached Reference Page

BILLING CODE: 02*
* New adds are charged only if enrolled on or before the 15th of the month. If enrolled after the 15th there is no premium. New terminates will be billed for the entire month if they are eligible for at least one day of that month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): The 1st of the month of coverage to be paid within 45 days except AB1401 to be paid within 15 days.
ANNUAL OUT-OF-POCKET LIMIT PER INDIVIDUAL: $ 1,500.00
ANNUAL OUT-OF-POCKET LIMIT PER FAMILY: $ 3,000.00
CONTINUATION OF BENEFITS ELECTIONS: Yes

ELIGIBILITY:
Group Eligibility
Minimum hours required per week: 30 FT, 20 PT

Dependent Member Eligibility
Dependent children are Eligible through age: 25

Start and End date of coverage: New employee's coverage starts on the first of the month following date of hire. No waiting period for Rehires. Coverage ends last day of month following date of termination.

A new spouse, Domestic Partner or children are eligible as set forth in the UnitedHealthcare of California Evidence of Coverage and Disclosure Form.

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**

- * Early Retiree Amendment
- * Premium Delay Amendment
- **A -** Schedule of Benefits, UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form
- **D -** Acupuncture/Chiropractic Services
- **I -** Infertility Basic Diagnosis and Treatment
- **L -** UnitedHealthcare of California Behavioral Health
- **R -** Outpatient Prescription Drug Benefit
- **S -** Real Appeal Rider

(8-28-02)
Updated 5/1/11 Legal Entity Name Change

Reference Page

Franklin-McKinley School District - UHC High Plan - SV Network	Group Code			Health Plan Premiums		
	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252074			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252075			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252076		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252340	$ 1,227.04	$ 2,454.08	$ 3,472.52
Active Classified Mgmt	252077			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated Mgmt	252078			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare	252079			$ 1,115.49	$ 2,230.98	$ 3,156.84
Self-Paid Ret w/out Medicare	252080			$ 1,115.49	$ 2,230.98	$ 3,156.84

Loma Prieta School District - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252108			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252109			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252110		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252346	$ 1,227.04	$ 2,454.08	$ 3,472.52

LGS Recreation - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active	252121			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252122		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252352	$ 1,227.04	$ 2,454.08	$ 3,472.52

Los Gatos Union School District - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252138			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252139			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Confidential	252140			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252141		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252357	$ 1,227.04	$ 2,454.08	$ 3,472.52
Active Classified Mgmt	252142			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated Mgmt	252143			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare	252144			$ 1,115.49	$ 2,230.98	$ 3,156.84

Luther Burbank School District - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252166			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252167			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252168		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252363	$ 1,227.04	$ 2,454.08	$ 3,472.52
Active Management	252169			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare	252170			$ 1,115.49	$ 2,230.98	$ 3,156.84

Milpitas Unified School District - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252198			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252199			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Confidential	252200			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252201		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252369	$ 1,227.04	$ 2,454.08	$ 3,472.52
Active Classified Management	252202			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated Management	252203			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare	252204			$ 1,115.49	$ 2,230.98	$ 3,156.84

Mountain View Whisman School District UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active	252229			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252230		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252375	$ 1,227.04	$ 2,454.08	$ 3,472.52
Retirees w/out Medicare - District Paid	252231			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare - Self Pay	252232			$ 1,115.49	$ 2,230.98	$ 3,156.84

Mount Pleasant School District - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified/Confidentials	252253			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252254			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Confidential	252255			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252256		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252381	$ 1,227.04	$ 2,454.08	$ 3,472.52
Active Management	252257			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated Management	252258			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare	252259			$ 1,115.49	$ 2,230.98	$ 3,156.84
Self-paid Retirees w/out Medicare	252260			$ 1,115.49	$ 2,230.98	$ 3,156.84

Orchard School District UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252281			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252282			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252283		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252387	$ 1,227.04	$ 2,454.08	$ 3,472.52
Retirees w/out Medicare	252284			$ 1,115.49	$ 2,230.98	$ 3,156.84

Sunnyvale School District - UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active Classified	252302			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated	252303			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Confidential	252304			$ 1,115.49	$ 2,230.98	$ 3,156.84
COBRA		252305		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252393	$ 1,227.04	$ 2,454.08	$ 3,472.52
Active Classified Mgmt	252306			$ 1,115.49	$ 2,230.98	$ 3,156.84
Active Certificated Mgmt	252307			$ 1,115.49	$ 2,230.98	$ 3,156.84
Retirees w/out Medicare	252308			$ 1,115.49	$ 2,230.98	$ 3,156.84

SIG Office Staff UHC High Plan - SV Network	Active	Cobra	AB1401	Employee Only	Employee + 1 Dependent	Employee + Family
Active	252019			$ 1,115.49	$ 2,230.98	$ 3,156.84
Cobra		252417		$ 1,115.49	$ 2,230.98	$ 3,156.84
AB1401			252411	$ 1,227.04	$ 2,454.08	$ 3,472.52

UnitedHealthcare of California

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Covered Services

There are changes in Federal law which may impact Covered Services stated in the *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for Health Plans that are new or renewing on or after September 23, 2010, the requirements listed below apply. (The *Patient Protection and Affordable Care Act (PPACA)* allows for exceptions to this effective date for collectively bargained groups.)

- If your Health Plan includes lifetime limits, lifetime limits on the dollar amount of essential benefits available to you under the terms of your Health Plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- If your Health Plan includes lifetime limits: On or before the first day of the first plan year beginning on or after September 23, 2010, the Employer Group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. If your Health Plan includes annual limits on essential benefits, restricted annual limits for each person covered under the Health Plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled Dependent children is no longer dependent upon full-time student or unmarried status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the Employer Group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the *PPACA* a Health Plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans*.

- If you do not have a grandfathered plan, Covered Services for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or Copayments. If you have pharmacy benefit coverage, your Health Plan may also be required to cover preventive care medications that are obtained at a participating pharmacy at 100%, and not subject to any deductible, coinsurance or Copayments, 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 States Preventive Services Task Force.*
    - 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*.
    - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Rescinding coverage under the Health Plan is permitted, with 30 days advance written notice, only in the following circumstances:
    - The individual performs an act, practice or omission that constitutes fraud.
    - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your Health Plan because your Health Plan already contains these benefits. These include:
    - Direct access to OB/GYN care without a referral or preauthorization requirement.
    - The ability to designate a pediatrician as a primary care physician.
    - Preauthorization is not required before you receive Covered Services in the emergency department of a hospital.
    - If you seek Emergency Services from non-Participating Providers in the emergency department of a hospital, your cost sharing obligations (Copayments/Coinsurance) will be the same as would be applied to Covered Services received from Participating Providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity (For Non-Grandfathered Small Groups with 50 or less employees:)

Effective for Health Plans that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008* (*MHPAEA*). Benefits for mental health conditions and substance use disorder conditions that are Covered Services under the Health Plan must be treated in the same manner and provided at the same level as Covered Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance

Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

For Employer Groups with 51 or more employees:

Effective for Health Plans that are new or renewing on or afterJuly 1, 2010, benefits are subject to final regulations supporting the *Mental Health Parity and Addition Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and/or substance use disorder conditions that are Covered Services under the Health Plan must be treated in the same manner and provided at the same level as Covered Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Copayments and coinsurance for mental health and/or substance use disorder conditions that are defined as Covered Services under the Health Plan must be no more restrictive than those Copayments and coinsurance requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and/or substance use disorder benefits that are covered under the Health Plan. Based upon the results of that testing, it is possible that Copayments that apply to mental health conditions or substance use disorder conditions covered under your Health Plan may be reduced.

Some Important Information About Appeal and Independent Medical Review (IMR) Rights Under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and Independent Medical Review **(IMR)** rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and **IMR** provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your plan sponsor, regarding the appeal rights available to you under your plan. (Also, please refer to the *Claims and Appeal Notice* section of this document).

- **What if I don't agree with the denial?** You have a right to appeal any decision not to pay for an item or service (in whole or in part).
- **How do I file an appeal?** Follow the instructions set forth in the initial denial notice that you receive from us.
- **What if my situation is urgent?** If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal, and, if applicable, a simultaneous **IMR** by contacting us at the number listed on the back of your ID card.
- **Who may file an appeal?** You or someone you name to act for you (your authorized representative) may file an appeal.
- **Can I provide additional information about my claim?** Yes, you may supply additional information to us regarding your claim at the address supplied to you in the initial denial notice.

- **Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge) by contacting us as set forth in the initial denial notice that you receive from us.
- **What happens if I don't agree with the outcome of my appeal?** If you appeal, we will review our decision and provide you with a written determination in accordance with applicable timeframes. If we continue to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may be able to request an **IMR** of your claim by an Independent Medical Review Organization (IRO) who will review the denial and issue a final decision.

Other resources that may be available to help you: For questions about appeal rights, an adverse benefit determination, or for assistance, you can contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272).

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-HMO-2219) and a TTY line (1-888-877-5378**) 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.

- **Are verbal interpretations or written translation services available to me during an appeal?** Yes. To get an interpreter or to ask about written information in your language, please call UnitedHealthcare at the number listed on the back of your health plan ID card.

Mental Health/Substance Use Disorder Parity

For Employer Groups with 51 or more employees:

Effective for Health Plans that are new or renewing on or after July 1, 2010, benefits are subject to final regulations supporting the *Mental Health Parity and Addition Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and/or substance use disorder conditions that are Covered Services under the Health Plan must be treated in the same manner and provided at the same level as Covered Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Copayments and coinsurance for mental health and/or substance use disorder conditions that are defined as Covered Services under the Health Plan must be no more restrictive than those Copayments and coinsurance requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and/or substance use disorder benefits that are covered under the Health Plan. Based upon the results of that testing, it is possible that Copayments that apply to mental health conditions or substance use disorder conditions covered under your Health Plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Covered Services are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Covered Services in connection with a mastectomy, Covered Services are also provided for the following Covered Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Services (including Copayments and any annual deductible) are the same as are required for any other Covered Service. Limitations on benefits are the same as for any other Covered Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans ("plans") and health insurance issuers ("issuers") offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. In any case, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your Combined Evidence of Coverage and Disclosure Form for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Covered Services after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have Covered Services for prescription drug benefits under your Health Plan and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Health Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the

applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Covered Services

Pre-service requests for Covered Services are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Covered Services, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Covered Services improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Covered Services was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Covered Services will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have Covered Services for prescription drug benefits under the Health Plan and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Covered Services in accordance with the applicable claim filing procedure. When you have filed a request for Covered Services, your request will be treated under the same procedures for pre-service group health plan requests for Covered Services as described in this section.

Urgent Requests for Covered Services that Require Immediate Attention

Urgent requests for Covered Services are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Covered Services improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the Health Plan provision on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Covered Services 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.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Service* department before requesting a formal appeal. If the *Customer Service* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Service* representative. If you first informally contact our *Customer Service* department and later wish to request a formal appeal in writing, you should again contact *Customer Service* and request an appeal. If you request a formal appeal, a *Customer Service* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Service* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

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

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Covered Services. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the 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.

Appeals Determinations

Pre-service Requests for Covered Services and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Covered Services as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Covered Services. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Covered Services, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Covered Services are available under the Health Plan for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The following is a general description of certain rights and protections applicable to Employer Groups subject to the Employment Retirement Income Security Act of 1974 (ERISA). Members should contact their Employer Group's benefit administrator to determine whether the Employer Group is subject to ERISA.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room of the Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The plan administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The plan sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group

health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U. S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Plan Year

If the Employer Group is subject to the *Employee Retirement Income Security Act of 1974 (ERISA)*, we will assume that the Employer Group's *ERISA* plan year is the same as the Employer Group's Health Plan renewal date, and update benefits to comply with Federal law upon renewal.

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

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

PCA494656-007

Fed Notice
6/14

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

Effective January 1, 2016

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

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

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

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

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

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

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

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

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

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents**. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

  1. HIV/AIDS;
  2. Mental health;
  3. Genetic tests;
  4. Alcohol and drug abuse;
  5. Sexually transmitted diseases and reproductive health information; and
  6. Child or adult abuse or neglect, including sexual assault.

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

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

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

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please **call the toll-free member phone number on your health plan ID card** or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-633-2446 (TTY 711).
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare Customer Service - Privacy Unit
  PO Box 740815
  Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[1]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD – Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2016

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 (TTY 711).

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on page four of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; Connextions HCI, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC,; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP HEALTH PLAN NOTICES OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2016

The first part of this Notice, which provides our privacy practices for Medical Information (pages 1-4), describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information **without your consent**.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IL, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

UnitedHealthcare

Medical Proposed Rates for SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP

Effective Date: 1/1/2021

Underwriting and Proposal Qualifications

This offer of renewal and the premium rates quoted are based on the information below. If there is any change to the information below, UnitedHealthcare reserves the right to rescind this offer of renewal and/or recalculate the premium rates quoted. Final rates are subject to the execution of the Group Subscriber Agreement/Group Policy.

1. This quote assumes the employer will contribute a minimum of 50% of the employee only premium.
2. UnitedHealthcare reserves the right to modify benefits or premium in connection with changes in federal or state premium tax, assessment, or benefit mandates that may be enacted during the course of the employer contract period. We will notify the group of the effective date and amount of any required benefit or premium changes.
3. This proposal assumes that UnitedHealthcare is offered with Kaiser of California. It is required that at least 75% of all eligible employees enroll for coverage, if the plan is written on a contributory basis. Those employees who are waiving due to other group coverage being in-force will not be counted toward this requirement. UnitedHealthcare requires that no less than 50% of the total eligible employees (including those who are waiving) participate in the plan. No additional carriers or products will be added.
4. The employer must meet the standards of a large group under State and Federal law.
5. Coverage for retirees of the employer is not included unless otherwise noted.
6. Premium rates assume a premium payment delay of 30 days. Premium rates have been loaded 0.50% to reflect this premium payment delay. This premium delay has been approved pursuant to your request, is valid for the current rating period, and is subject to the terms of the Subscriber Agreement between you and UnitedHealthcare. Please notify your UnitedHealthcare Sales Representative if you would prefer UnitedHealthcare's standard payment provision whereby premium is due no later than the first day of the month for which coverage is to be provided. If you select this option, the premium load will be removed from the premium rates.
7. Commissions are based on a flat 1.00%.
8. If another carrier offers an off-cycle open enrollment not agreed to by UnitedHealthcare, we reserve the right to re-rate or terminate coverage.
9. In order for a broker to be paid commissions, the broker must be both licensed and appointed in the required State by UnitedHealthcare in advance of the effective date. Commissions may not be paid for months for which the broker is not appointed.
10. The Maximum Non-Network Reimbursement Program (MNRP) protocol will apply for eligible claim categories. MNRP equates to 110% of regional Medicare rates, or 50% of billed charges if Medicare is not available.
11. Rates are based on your current system census.
12. This premium may include state and federal taxes and fees.
13. The Federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, became law on March 23, 2010. Some provisions of the new reform law started taking effect in 2014 while other provisions will become effective each year over the balance of this decade. Certain provisions are unclear and require additional guidance from the federal regulators. Without this additional guidance, there is little clarity on exactly how the many requirements of the new law will impact certain plan provisions or plan changes. We are providing this response based on our current understanding of the new law, and cannot represent that your plan will comply with future regulatory guidance. Please consult with your legal counsel regarding compliance with the new law.
14. Quotation of current plans assumes that the employer will maintain the same percentage contribution to the employee premium that was in effect on March 23, 2010. Changes to the contribution level may cause a plan to lose grandfathered status under the Affordable Care Act. The employer should consult with its own legal counsel concerning compliance with the requirements of that Act.
15. Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators, we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.
16. This proposed quote applies only to fully insured customers that are not eligible for community rated rates under PPACA.
17. This quote may include the managed care organization provider tax (“MCO tax”). UnitedHealthcare is subject to and fully compliant with the tax requirements.
18. The benefits quoted in this proposal assume they are not coupled with an HRA. If an HRA is added, revised rates will be produced based on the HRA level of benefits. HSA SelectPlus plans are not eligilble to have an HRA benefit.
19. Employee contributions for UnitedHealthcare’s SignatureValue Alliance product must be the same or lower across all enrollment rating tiers, by dollar amount, as any other carrier’s offering, regardless of benefit design differential. Whenever SignatureValue Alliance is the only product and network offered by UnitedHealthcare next to any staff model HMO or next to any other carrier(s), so long as payroll contribution parity is met, a minimum enrollment of 15 subscribers is required.

The benefits described in this proposal are subject to change and are not guaranteed to match benefits that may actually be approved.
It has been our privilege to serve you and your employees during the past year. We hope to remain your preferred provider of health benefits.

Strategic Account Executive / Account Executive Signature **Date**

UnitedHealthcare

Medical Proposed Rates for SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP

Effective Date: 1/1/2021

Underwriting and Proposal Qualifications

This offer of renewal and the premium rates quoted are based on the information below. If there is any change to the information below, UnitedHealthcare reserves the right to rescind this offer of renewal and/or recalculate the premium rates quoted. Final rates are subject to the execution of the Group Subscriber Agreement/Group Policy.

20. Premium rates assume a retro eligibility period of 60 days. Premium rates have been loaded 0% to reflect this retro eligibility period. This retro eligibility period has been approved pursuant to your request, is valid for the current rating period, and is subject to the terms of the Subscriber Agreement between you and UnitedHealthcare. UnitedHealthcare will retain the premium if any claims have been paid during the retroactive time period.

21. This offer of renewal assumes that premiums will be paid to date on the renewal date of the plan. Delinquency processing or termination as a result of non-payment of premium will supercede this offer of renewal and coverage will be terminated effective the last day for which premiums were received.

22. These premium rates are based on the current enrollment census and carrier participation. If there is a change in carrier offerings (including changes in benefits, products and contributions) or if the enrollment should fluctuate because of changes made by a competitor (or the employer group), UnitedHealthcare reserves the right to re-rate the premium.

23. If the demographics used in the preparation of this proposal vary by more than 10% of those actually enrolling, UnitedHealthcare reserves the right to re-rate the premium.

24. Plan design and corresponding premium rates offered herein represent a coverage option that is consistent with your current group size (based on most recent census or survey information) and closely matches your current coverage. Additional coverage options may be available to you.

25. If your plan is grandfathered, medical or pharmacy plan changes may result in a loss to your grandfathered status.

26. The premium rates reflected in this proposal assume that the copays and any other out-of-pocket costs are fully funded by the employee. If the employer chooses to fund a portion of the out-of-pocket costs, then the total rates will be adjusted.

27. UnitedHealthcare's renewal is contingent upon receipt of certification from the consultant, broker or group of benefit parity among the health plans offered, including both fully insured and self-funded plans. In instances where benefit parity does not exist, the responsible party will provide a summary of the key differences in the benefits offered and UnitedHealthcare reserves the right to appropriately modify its benefits and rates to achieve benefit parity. Parity in this context means the same or equivalent actuarial value.

28. Premium rates assume an allowance of up to $150,000 to be used by the client for costs incurred by them for wellness associated purposes. These funds must be used by 12/31/2021, and any unused funds are not refundable by UnitedHealthcare.

The benefits described in this proposal are subject to change and are not guaranteed to match benefits that may actually be approved. It has been our privilege to serve you and your employees during the past year. We hope to remain your preferred provider of health benefits.

_____ _____

Strategic Account Executive / Account Executive Signature **Date**

EARLY RETIREE AMENDMENT TO THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT BETWEEN UHC OF CALIFORNIA DOING BUSINESS AS UNITEDHEALTHCARE OF CALIFORNIA ("UNITEDHEALTHCARE") AND SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP ("GROUP")

This **EARLY RETIREE AMENDMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA, MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT** (this "Amendment"), dated as of January 1, 2021 is made and entered into by and between UnitedHealthcare of California, a California corporation ("UnitedHealthcare") and Santa Clara County Schools' Insurance Group ("Group").

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, UnitedHealthcare agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Medical and Hospital Group Subscriber Agreement, including the Cover Sheet and Attachments.

The Group Agreement shall be amended to read as follows:

[1]. SECTION [1.] DEFINITIONS

[1.] DEFINITIONS

1.06 Eligible Employee is deleted in its entirety and replaced with the following:

1.06 Early Retiree is a former Group employee who has met the minimum required Retiree participation conditions as determined by Group, who is not entitled to Medicare Parts A and B, who meets the Subscriber eligibility requirements of the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form, who is enrolled in the UnitedHealthcare Early Retiree Health Plan, and for whom all applicable Health Plan Premiums are received by UnitedHealthcare.

1.16 Subscriber shall be amended to read as follows:

1.16 Subscriber/Eligible Retiree is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by UnitedHealthcare, and whose retirement or other status, except for family dependency, is the basis for enrollment eligibility.

2. Effect of this Amendment. The Amendment shall not be further amended, modified or revised and the Agreement shall continue in full force and effect and shall be enforced in accordance with its terms and conditions. **This amendment shall expire on December 31, 2021.**

AMENDMENT TO THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT BETWEEN UHC OF CALIFORNIA DOING BUSINESS AS UNITEDHEALTHCARE OF CALIFORNIA ("UNITEDHEALTHCARE") AND SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP ("GROUP")

This **AMENDMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA, MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT** (this "Amendment"), dated as of January 1, 2021, is made and entered into by and between UnitedHealthcare of California, a California corporation ("UnitedHealthcare") and Santa Clara County Schools' Insurance Group ("Group").

Amendment. Pursuant to Section 3.07 of the Agreement, the benefits set forth in the Agreement are hereby amended as follows:

SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

3.06 Due Date shall be amended to read as follows:

3.06 Due Date. Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to UnitedHealthcare on or before the 1st day of the month, within 45 days from date for which premium applies. Failure to provide payment on or before the due date may result in termination of Group as set forth in Section 7.02.01 below. UnitedHealthcare reserves the right to assess an administrative fee of five (5) percent of the monthly premium prorated on a 30-day month for each day it is delinquent thereafter. This fee will be assessed solely at UnitedHealthcare's discretion. In the event that deposit of payment not made in a timely manner are received by UnitedHealthcare after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by UnitedHealthcare within twenty (20) business days of receipt if UnitedHealthcare, in its sole discretion, does not reinstate Group.

Effect of this Amendment. The Amendment shall not be further amended, modified or revised and the Agreement shall continue in full force and effect and shall be enforced in accordance with its terms and conditions. This Amendment shall expire on December 31, 2021.

Amendment to UnitedHealthcare of California Medical and Hospital Group Subscriber Agreement

This **AMENDMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT** (this "Amendment"), dated as of February 1, 2011, is made pursuant to Section 3.07.02 of the Medical and Hospital Group Subscriber Agreement (the "Agreement"), dated January 1, 2021, between UnitedHealthcare of California, a California corporation ("UnitedHealthcare"), and you ("Group").

Green Initiative. UnitedHealthcare has launched a green initiative which includes efforts to conserve and minimize the use of paper whenever possible. As part of UnitedHealthcare's green initiative, it will provide the UnitedHealthcare Enrollment Packet to Group in electronic form.

Amendment. Pursuant to Section 3.07.02 of the Agreement, Section 2.01.03 of the Agreement is hereby amended by inserting the following sentence as the first sentence of such section:

"UnitedHealthcare shall provide the UnitedHealthcare Enrollment Packet to Group in electronic form and the Plan shall ensure receipt of the packet along with a notification of the right to receive a hard copy of the packet as set forth in SECTION 10 below. If Group does not wish to receive the UnitedHealthcare Enrollment Packet in electronic form, Group may so notify UnitedHealthcare in accordance with Section 8.11 of the Agreement, and thereafter UnitedHealthcare will deliver the UnitedHealthcare Enrollment Packet to Group in paper format. The terms and conditions for Groups who transmit the UnitedHealthcare Enrollment Packet to its employees electronically are in SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENT."

All other provisions of Section 2.01.03 remain unchanged.

The following item is added to SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENT.

3.10 ENROLLMENT PACKETS

1. The following provisions apply to Groups agreeing to receive the Enrollment Packets electronically for distribution to their employees.

   1.1 Group agrees to distribute an unmodified, electronic copy of the Enrollment Packet. Group agrees to send the Enrollment Packets to all employees and to use appropriate and necessary means to ensure receipt of the Enrollment Packets;

   1.2 Group agrees to protect the confidentiality of the employees' personal information relating to the individual's account or benefits (e.g., incorporating measures designed to preclude unauthorized receipt of, or access to, such information other than the intended individual);

   1.3 Group agrees to provide access to computer programs and/or software required to read the Enrollment Packet and access to a printer.

2. Group agrees that it will provide Enrollment Packets in accordance with all applicable state or federal laws. In providing Enrollment Packets in electronic form, Group shall ensure that no modifications to Enrollment Packets will be made which affect the style, format or content of the Enrollment Packets in any manner.

3. Employees receiving the Enrollment Packet electronically will also receive an electronic notification that they may request a hard copy of the packet from the Plan. Group agrees that it will continue to provide Enrollment Packets in paper form to those employees who request a hard copy or do not have access to the electronic Enrollment Packet. Group is responsible to make sure that each employee receives the electronic Enrollment Packet, including providing a hard copy if an undeliverable message is received. UnitedHealthcare shall provide Enrollment Packets in paper form to the Group for distribution to UnitedHealthcare enrollees as they may request.

4. Group agrees that it will make the Enrollment Packet available to employees prior to the Group's renewal or during the entire open enrollment period. UnitedHealthcare agrees to make the Enrollment Packets available to Group as reasonably required by Group. Upon request, Group agrees to provide UnitedHealthcare with confirmation that employees received electronic and/or hard copy of the Enrollment Packet.

The following section is added to the Medical and Hospital Group Subscriber Agreement:

10. UNITEDHEALTHCARE'S OBLIGATIONS

UnitedHealthcare will provide the Agreement to the Group in electronic form through electronic media which may be furnished through the Internet or other electronic communication network. UnitedHealthcare will provide, along with the Agreement, electronic notification of the right to request hard copy. UnitedHealthcare will ensure receipt of the electronic documents through reasonable and necessary measures such as return-receipt or notice of undeliverable electronic mail features, and, in the event the electronic transmission fails, a hard copy of the Agreement will be furnished to the Group.

Effect of this Amendment. Pursuant to Section 3.07.02 of the Agreement, this Amendment shall take effect commencing the first full month following a thirty (30) day period after delivery of this Amendment to Group. The Agreement, as modified by this Amendment, shall continue in full force and effect and shall be enforced in accordance with its terms and conditions.

UHC OF CALIFORNIA dba UNITEDHEALTHCARE OF CALIFORNIA

MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

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MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

This Medical and Hospital Group Subscriber Agreement (the “Agreement”) is entered into between UHC of California dba United Healthcare of California, a California corporation, hereinafter called "UnitedHealthcare," and the employer, association or other entity specified as "GROUP" on the Cover Sheet, hereinafter called "Group."

RECITAL OF FACTS

UnitedHealthcare is a health care service plan which arranges for the provision of medical, hospital and preventive medical services to persons enrolled as Members through contracts with associations of licensed physicians, hospitals and other health care providers. Group is an employer, union, trust, organization, or association which desires to provide such health care for its eligible Subscribers and family Dependents. UnitedHealthcare desires to contract with Group to arrange for the provision of such health care services to Subscribers and family Dependents of Group, and Group desires to contract with UnitedHealthcare to arrange for the provision of such services to its Subscribers and family Dependents.

AGREEMENT

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, UnitedHealthcare agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Medical and Hospital Group Subscriber Agreement, including the Cover Sheet and Attachments.

1. DEFINITIONS

1.01 Agreement is this Medical and Hospital Group Subscriber Agreement, including, but not limited to, the Cover Sheet, Attachments and any amendments thereto.

1.02 Combined Evidence of Coverage and Disclosure Form is the document issued to prospective and enrolled Subscribers disclosing and setting forth the benefits and terms and conditions of coverage to which Members of the Health Plan are entitled.

1.03 Copayments are fees payable to a health care provider by the Member at the time of provision of services which are in addition to the Health Plan Premiums paid by the Group. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

1.04 Cover Sheet is the Medical and Hospital Group Subscriber Agreement Cover Sheet which is attached to and an integral part of this Agreement.

1.05 Dependent is any spouse, Domestic Partner or child (including a step-child, adopted child, child(ren) for whom the Subscriber, the Subscriber's spouse or Domestic Partner has assumed permanent guardianship or a child of a Domestic Partner) of a Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form attached to this Agreement and for whom applicable Health Plan Premiums are received by UnitedHealthcare.

1.05(a) Domestic Partner is a person who meets the eligibility requirements, as defined by the 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:
   a. 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.
   b. 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.

1.06 Eligible Employee is a Group employee who works a fixed number of hours per week as established by the Group, meets any applicable waiting period required by the Group, and meets the following additional criteria:

(a) Is defined as an employee under state and federal law;

(b) Is actively working or is able to return to active work and has certain rights pertaining to leaves of absence if his or her condition improves. Consultants, temporary labor, suppliers or contractors are not Eligible Employees.

1.07 Enrollment is the execution of a UnitedHealthcare Enrollment form, or a non-standard Enrollment form approved by UnitedHealthcare, by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by UnitedHealthcare, conditioned upon the execution of this Agreement by UnitedHealthcare, and either the execution of this Agreement by Group or the timely payment of applicable Health Plan Premiums by Group. In its discretion and subject to specific protocols, UnitedHealthcare may accept Enrollment through an electronic submission from Group.

1.08 Group is the single employer, labor union, trust, organization, or association identified on the Cover Sheet.

1.09 Group Contribution is the amount of the Health Plan Premium applicable to each Subscriber which is paid solely by the Group or employer and which is not paid by the Subscriber either through payroll deduction or otherwise.

1.10 Group Participation is the number of individuals in the Group who are enrolled as Subscribers expressed as a percentage of the number of individuals in the Group who are eligible to enroll as Subscribers.

1.11 Health Plan is the health plan described in this UnitedHealthcare Medical and Hospital Group Subscriber Agreement, Cover Sheet and Attachments, subject to modification pursuant to the terms of this Agreement.

1.12 Health Plan Premiums are amounts established by UnitedHealthcare to be paid to UnitedHealthcare by Group on behalf of Members in consideration of the benefits provided under this Health Plan; such amounts are set forth in the Cover Sheet of this Agreement.

1.13 Member is the Subscriber or any Dependent who is eligible, enrolled and covered by the UnitedHealthcare.

1.14 Open Enrollment Period is the annual period of not less than thirty (30) days agreed upon by UnitedHealthcare and Group, during which all eligible and prospective Group Subscribers and their eligible Dependents may enroll in this Health Plan.

1.15 UnitedHealthcare Enrollment Packet is the packet of information supplied by UnitedHealthcare to prospective Members which discloses plan policy and procedure and provides information about Plan benefits and exclusions. The UnitedHealthcare Enrollment Packet contains the UnitedHealthcare Enrollment form or a non-standard Enrollment form approved by UnitedHealthcare, and the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form.

1.16 Subscriber is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by UnitedHealthcare, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

2. ELIGIBILITY AND ENROLLMENT

2.01 Enrollment Procedure

2.01.01 Application Form. A properly completed, signed application for Enrollment on a form provided by UnitedHealthcare, or on a non-standard form approved by UnitedHealthcare, must be submitted to UnitedHealthcare by Group for each eligible and/or prospective Subscriber, on behalf of the eligible and/or prospective Subscriber and any eligible Dependents. UnitedHealthcare may, in its discretion and subject to specific protocols, accept Enrollment through an electronic submission from Group.

2.01.02 Time of Enrollment. All applications for Enrollment shall be submitted by prospective Subscribers to the Group during Open Enrollment Periods, except that prospective Subscribers and their eligible Dependents who were not eligible during the previous Open Enrollment Period may apply for Enrollment within thirty-one (31) days after becoming eligible. All applications for Enrollment which are not received by UnitedHealthcare within the thirty-one (31) days from the first day the prospective Subscriber or Dependent becomes eligible shall be subject to rejection by UnitedHealthcare. Prospective Subscribers and their eligible Dependents may reapply at the next Open Enrollment Period in the event an application was not received by UnitedHealthcare within such thirty-one (31) day period. Group shall provide notice to Members of the applicable Open Enrollment Periods.

2.01.03 Notice and Certification. Group shall provide a written notice and certification, prepared by UnitedHealthcare, as part of the UnitedHealthcare Enrollment Packet to Eligible Employees at the commencement of the initial Open Enrollment Period. The written notice and certification section of the UnitedHealthcare application for Enrollment shall provide notice of the availability of coverage under the Health Plan and indicate that an Eligible Employee's failure to elect coverage, on his or her behalf or on behalf of his or her eligible Dependents during the initial Open Enrollment Period, permits UnitedHealthcare to exclude coverage for a period of up to twelve (12) months until the Employer's next open enrollment period. Group shall require any Eligible Employee declining coverage under the Health Plan on behalf of himself or herself or any eligible Dependent, to certify on the written notice and certification prepared by UnitedHealthcare, the reason for declining Enrollment in the Health Plan and that he or she has reviewed the notice and certification and understands the consequences of declining coverage under the Health Plan. Group agrees to submit all completed notices and certifications to UnitedHealthcare for:

a. Each Eligible Employee and/or his or her eligible Dependents who declined coverage at renewal of this Agreement; and

b. Each Eligible Employee and/or his or her eligible Dependents who became eligible during the term of this Agreement specified on the Cover Sheet of this Agreement and who have declined coverage.

2.01.04 Late Enrollment. Please refer to the section of this Agreement entitled Combined Evidence of Coverage and Disclosure Form for a complete description of Late Enrollment procedures.

2.02 Commencement of Coverage. The commencement date of coverage under this Health Plan shall be effective in accordance with the terms of the Cover Sheet and this Agreement. UnitedHealthcare's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Health Plan Premium payment.

2.03 UnitedHealthcare's Liability in the Event of Conversion from a Prior Carrier. In the event UnitedHealthcare replaces a prior carrier responsible for the payment of benefits or provision of services under a group contract within a period of sixty (60) days from the date of discontinuation of the prior contract or policy, UnitedHealthcare will immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuation, and who are eligible for enrollment under this Agreement, without regard to health status or hospital confinement. Notwithstanding the foregoing, with respect to employees or dependents who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code or Section 10128.2 of the California Insurance Code under the prior contract or policy, UnitedHealthcare shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

3.01 Non-Discrimination. Group shall offer UnitedHealthcare an opportunity to market this Health Plan to its employees and shall offer its employees an opportunity to enroll in this Health Plan under no less favorable terms or conditions than Group offers enrollment in other health care service plans or employee health benefit plans.

3.02 Notices to UnitedHealthcare. Group shall forward all completed or amended Enrollment forms for each Member for receipt by UnitedHealthcare within thirty-one (31) days of the Member’s initial eligibility. Group acknowledges that any Enrollment applications not received by UnitedHealthcare within such thirty-one (31) day period may be rejected by UnitedHealthcare. Group further agrees to transmit to UnitedHealthcare any Enrollment application amendments.

Group shall forward all notices of termination to UnitedHealthcare within thirty-one (31) days after Member loses eligibility or elects to terminate membership under this Agreement. Group agrees to pay any applicable Member Health Plan Premiums through the last day of the month in which notice of termination is received by UnitedHealthcare.

3.03 Notices to Member. If Group or UnitedHealthcare terminates this Agreement pursuant to Section 7 below, Group shall promptly notify all Members

enrolled through Group of the termination of their coverage in this Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from UnitedHealthcare to Group at the Subscriber's then current address. Group shall promptly provide UnitedHealthcare with a copy of the notice of termination delivered to each Subscriber, along with evidence of the date the notice was provided. In the event that UnitedHealthcare terminates this Agreement for non-payment of Health Plan Premiums or rescinds this Agreement for fraud or an intentional misrepresentation of a material fact, Members will receive notice of termination from UnitedHealthcare. Group shall notify all Members of coverage options through the Exchange and Medi-Cal in compliance with Section 1366.50 and provide the Plan with a written acknowledgement or other acceptable electronic acknowledgement.

If, pursuant to Sections 3.07.01 and 3.07.02 below, UnitedHealthcare increases Health Plan Premiums payable by the Subscriber, or if UnitedHealthcare increases Copayments or reduces covered services provided under this Agreement, Group shall promptly notify all Members enrolled through Group of the increase or reduction. In addition, Group shall promptly notify Members enrolled through Group of any other changes in the terms or conditions of this Agreement affecting the Members' benefits or obligations under the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the Health Plan Premium or Copayment increase or reduction in covered services sent from UnitedHealthcare to Group at the Subscriber's then current address. Group shall promptly provide UnitedHealthcare with a copy of the notice of Health Plan Premium or Copayment increase or reduction in covered services delivered to each Subscriber, along with evidence of the date the notice was provided. UnitedHealthcare shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.03.

3.03.01 Summary of Benefits and Coverage. The Plan will provide a Summary of Benefits and Coverage ("SBC"), as required by the Affordable Care Act and associated regulations ("ACA"), to the Group for each benefit plan purchased by the Group. The Group shall be responsible for delivering the SBC to all Members and to other persons eligible for coverage in the manner and at the times required by the ACA, unless we notify the Enrolling Group that we will deliver the SBC to Members and other persons eligible for coverage.

3.04 Indemnification. Group agrees to indemnify, defend and hold UnitedHealthcare harmless and accept all legal and financial responsibility for any liability arising out of Group's failure to perform its obligations as set forth in this Section 3.

3.05 Rates (Prepayment Fees). The Health Plan Premium rates are set forth in the Health Plan Premiums section of the Cover Sheet and supplemental Health Plan Premium notices.

3.06 Due Date . Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to UnitedHealthcare on

or before the last business day of the month prior to the month for which the premium applies. Failure to provide payment on or before the due date may result in termination of Group, as set forth in Section 7.02.01 below. UnitedHealthcare reserves the right to assess an administrative fee of five percent (5%) of the monthly premium prorated on a thirty (30)-day month for each day it is delinquent thereafter. This fee will be assessed solely at UnitedHealthcare's discretion. In the event that deposit of payments not made in a timely manner are received by UnitedHealthcare after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by UnitedHealthcare within twenty (20) business days of receipt if UnitedHealthcare, in its sole discretion, does not reinstate Group.

3.07 Modification of Rates and Benefits.

3.07.01 Modification of Health Plan Premium Rates. The Health Plan Premium rates set forth on the Cover Sheet and the UnitedHealthcare Enrollment Packet may be modified by UnitedHealthcare in its sole discretion upon sixty (60) days prior written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the sixty (60)-day notice period.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon UnitedHealthcare a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by UnitedHealthcare's gross receipts or any portions of either, then upon sixty (60) days written notice to Group, Group shall remit to UnitedHealthcare, with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees, rounded to the nearest cent.

3.07.02 Modification of Benefits or Terms. UnitedHealthcare shall provide the UnitedHealthcare Enrollment Packet to Group in electronic form and the Plan shall ensure receipt of the packet along with a notification of the right to receive a hard copy of the packet as set forth in SECTION 10 below. If Group does not wish to receive the UnitedHealthcare Enrollment Packet in electronic form, Group may so notify UnitedHealthcare in accordance with Section 8.11 of the Agreement, and thereafter UnitedHealthcare will deliver the UnitedHealthcare Enrollment Packet to Group in paper format. The terms and conditions for Groups who transmit the UnitedHealthcare Enrollment Packet to its employees electronically are in SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENT.

The covered services set forth in the Combined Evidence of Coverage and Disclosure Form, the Schedule of Benefits, and the Schedule of Supplemental Benefits in the UnitedHealthcare Enrollment Packet, as well as other terms of this Agreement, may be modified by UnitedHealthcare in its sole discretion upon sixty (60) days written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the sixty (60)-day notice period.

3.08 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by UnitedHealthcare are entitled to health care benefits as described in this Agreement, and then only for the period for which such payment is received. Group agrees to pay premium to UnitedHealthcare for the first month of coverage for newborn or adopted children who become eligible as provided in the Combined Evidence of Coverage and Disclosure Form section of this Agreement.

3.09 Continuation of Benefits

3.09.01 Notice Regarding Continuation Coverage**.** With the exception of Domestic Partners and their Dependents, upon the occurrence of a qualifying event, as defined by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended by the 1986 Tax Reform Act (P.L. 99-514) and the 1986 Omnibus Budget Reconciliation Act (P.L. 99-509) ("COBRA"), Group shall provide affected Members with written notice of available continuation coverage as required by and in accordance with COBRA and amendments thereto. Group shall be solely responsible for collecting Health Plan Premiums from Members who elect to continue benefits under COBRA and shall transmit such Health Plan Premiums to UnitedHealthcare along with the Group's Health Plan Premiums otherwise due under this Agreement. Group shall maintain accurate records regarding Health Plan Premiums for Members who elect to continue benefits, including qualifying events, terminating events, and other information necessary to administer this continuation of benefits. The obligations to be performed by Group under this Subsection may be performed directly by Group, or wholly or in part through a subsidiary or affiliate of Group, or on behalf of Group by a third party, including but not limited to a COBRA coverage administrator; provided that Group will remain liable to UnitedHealthcare for satisfaction of the obligations to be performed by Group under this Subsection. UnitedHealthcare is not responsible for the acts or omissions of Group or designee and shall be held harmless for any failure by Group to fulfill its obligations, including but not limited to failure to provide proper notice or failure to forward premium payments to UnitedHealthcare within applicable statutory time frames.

3.10 Enrollment Packets

1. The following provisions apply to Groups agreeing to receive the Enrollment Packets electronically for distribution to their employees.

   1.1 Group agrees to distribute an unmodified, electronic copy of the Enrollment Packet. Group agrees to send the Enrollment Packets to all employees and to use appropriate and necessary means to ensure receipt of the Enrollment Packets;

   1.2 Group agrees to protect the confidentiality of the employees' personal information relating to the individual's account or benefits (e.g., incorporating measures designed to preclude unauthorized receipt of or access to such information other than the intended individual);

1.3 Group agrees to provide access to computer programs and/or software required to read the Enrollment Packet and access to a printer.

2. Group agrees that it will provide Enrollment Packets in accordance with all applicable State or federal laws. In providing Enrollment Packets in electronic form, Group shall ensure that no modifications to Enrollment Packets will be made which affect the style, format or content of the Enrollment Packets in any manner.

3. Employees receiving the Enrollment Packet electronically will also receive an electronic notification along with the electronic Enrollment Packet that they may request a hard copy of the packet from the Plan. Group agrees that it will continue to provide Enrollment Packets in paper form to those employees who request a hard copy or do not have access to the electronic Enrollment Packet. Group is responsible each employee receives the electronic Enrollment Packet, including providing a hard copy if an undeliverable message is received. UnitedHealthcare shall provide Enrollment Packets in paper form to the Group for distribution to UnitedHealthcare enrollees as they may request.

4. Group agrees that it will make the Enrollment Packet available to employees prior to the Group's renewal or during the entire open enrollment period. UnitedHealthcare agrees to make the Enrollment Packets available to Group as reasonably required by Group. Upon request, Group agrees to provide UnitedHealthcare with confirmation that employees received electronic and/or hard copy of the Enrollment Packet.

4. BENEFITS AND CONDITIONS FOR COVERAGE

The attached UnitedHealthcare Combined Evidence of Coverage and Disclosure Form, Schedule of Benefits, and additional related attachments included at the end of this Agreement, are an integral part of this Agreement, and include a complete description of the Benefits and Conditions of Coverage of this Health Plan.

5. PARTIES AFFECTED BY THIS AGREEMENT; RELATIONSHIPS BETWEEN PARTIES

5.01 Relationship of Parties. Group is not the agent or representative of UnitedHealthcare and shall not be liable for any acts or omissions of UnitedHealthcare, its agents, employees or providers, or any other person or organization with which UnitedHealthcare has made, or hereafter shall make, arrangements for the performance of services under this Health Plan. Member is not the agent or representative of UnitedHealthcare and shall not be liable for any acts or omissions of UnitedHealthcare, its agents or employees.

5.02 Compliance with the Health Insurance Portability and Accountability Act of 1996. UnitedHealthcare agrees to furnish written certification of prior creditable coverage ("Certificates") to all eligible Members, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). UnitedHealthcare and Group acknowledge that UnitedHealthcare's agreement to issue Certificates to all eligible Members relieves Group of its obligation under HIPAA to furnish Certificates. Group acknowledges that UnitedHealthcare must rely completely on eligibility information and data (including, but not limited to, Member's name and current address) furnished by Group in issuing Certificates to Members. Group agrees to notify UnitedHealthcare of all terminations within thirty (30) days of the termination, and to provide UnitedHealthcare with eligibility information and data within thirty (30) days of its receipt or change. Group agrees to indemnify, defend and hold UnitedHealthcare harmless and accept all legal, financial and regulatory responsibility for any liability arising out of UnitedHealthcare's furnishing Certificates to eligible members under HIPAA.

6. TERM OF AGREEMENT; RENEWAL PROVISIONS, GRACE PERIOD

6.01 Term; Automatic Renewal. The term of this Agreement shall be one (1) year, commencing on the Group Coverage Effective Date set out in the Cover Sheet, unless otherwise indicated on the Cover Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement or as indicated on the Cover Sheet, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits pursuant to Section 3.07.

6.02 Grace Period. A grace period of [30] days shall be granted for the payment of any Health Plan Premium, during which time this Agreement shall continue in force. For premiums still unpaid at the end of the [30] day grace period, UnitedHealthcare will send a notice of termination with appeal rights to the Group and directly to the Members.

7. TERMINATION AND RESCISSION OF COVERAGE

7.01 Termination by Group. Group may terminate this Agreement by giving a minimum of thirty (30) days written notice of termination to UnitedHealthcare. Group termination must always be effective on the first day of the month. Group shall continue to be liable for Health Plan Premiums for all Members enrolled in this Health Plan through Group until the date of termination.

7.02 Termination by UnitedHealthcare.

7.02.01 For Nonpayment of Health Plan Premiums. UnitedHealthcare may

terminate this Agreement in the event Group or its designee fails to remit Health Plan Premiums in full by the end of the grace period as set forth in Section 6.02 by giving written notice of termination of this Agreement via first class mail to Group. Nonpayment of Health Plan Premiums includes but is not limited to, payments returned due to non-sufficient funds (NSF) and post-dated checks. Such notice shall specify that payment of all unpaid Health Plan Premiums must be received by UnitedHealthcare within thirty (30) days of the date of issuance of the notice, and that if payment is not received within the thirty (30) day period, no further notice shall be given, and coverage for all Members enrolled in this Health Plan shall automatically be terminated effective at the end of the month for which Health Plan Premiums have been actually received by UnitedHealthcare, subject to compliance with notice requirements. After the initial issuance of the notice to Group, UnitedHealthcare will send a HIPAA Certificate of Creditable Coverage to the Subscribers, notifying the Subscriber's that their health care coverage and their Dependent's health care coverage under this Plan has terminated effective the first of the month for which Health Plan Premiums were not received.

7.02.01.01 Reinstatement Following Non-Payment of Premium. Notwithstanding Section 7.02.01, receipt by UnitedHealthcare of all Health Plan Premium payments then due and owing on or before the succeeding Health Plan Premium payment due date will reinstate this Agreement as though it had never been terminated. However, UnitedHealthcare may, in its discretion, elect not to reinstate this Agreement in any of the following circumstances: (1) the notice of termination states that, if Health Plan Premium payment is not received within thirty (30) days of issuance of the notice of termination, a new application is required and identifies conditions under which a new agreement will be issued or this Agreement reinstated; (2) if payment of Health Plan Premiums is received by UnitedHealthcare more than thirty (30) days after the issuance of notice of termination, and the Plan refunds such payment within twenty (20) business days of receipt; or, (3) if payment of Health Plan Premiums is received more than thirty (30) days after issuance of the notice of termination, and UnitedHealthcare issues to Group, within twenty (20) business days of receipt of such Health Plan Premiums, a new Agreement accompanied by written notice stating clearly those respects in which the new Agreement differs from this Agreement in benefits, coverage or otherwise. In the event UnitedHealthcare receives untimely payments after Group has been terminated, the deposit or application of such funds by UnitedHealthcare does not constitute acceptance of such funds or reinstate group, and such funds may be refunded by UnitedHealthcare at its sole discretion.

7.02.03 For Fraud or an Intentional Misrepresentation of a Material Fact. UnitedHealthcare may terminate this Agreement thirty (30) days after UnitedHealthcare sends written notice to Group if 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 this Agreement (including any omissions, misrepresentations, or inaccuracies in the application form) or to the provision of coverage under this Agreement. In this case, UnitedHealthcare has the right to rescind this Agreement back to either:

(a) the date of this Agreement; or
(b) the date of the act, practice or omission, if later.

UnitedHealthcare will send a notice to the Group and Subscriber via certified mail at least 30 days prior to the effective date of the rescission explaining the reason for the rescission and notifying them of their right to appeal pursuant to Section 7.04.

UnitedHealthcare shall not rescind this Agreement due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Agreement pursuant to Section 8.17.

In the event that UnitedHealthcare does not terminate coverage or rescind this Agreement due to fraud or an intentional misrepresentation of a material fact, UnitedHealthcare reserves the right to increase Health Plan Premiums retroactive to the original effective date of this Agreement as described in the Group Enrollment form.

7.02.04 For Ceasing to Meet Group Eligibility Criteria. UnitedHealthcare may terminate Group upon sixty (60) days written notice to Group if Group fails to meet any of the following Group eligibility requirements:

(a) Group fails to maintain active Group Participation percentage of seventy-five percent (75%);

(b) For Subscribers without Dependents, Group fails to maintain a Group Contribution equal to fifty percent (50%) of the Health Plan Premium;

(c) For Subscribers with Dependents, Group fails to maintain a Group Contribution equal to the dollar amount of the Group Contribution for Subscribers without Dependents;

(d) Group fails to abide by and enforce the conditions of Subscriber Enrollment set forth in this Agreement.

(e) Group fails to meet the eligibility requirements established by the Group and UnitedHealthcare, including:

(i) All Subscribers must have a Primary Residence within California; or
(ii) All Subscribers must have a Primary Residence or Primary Workplace within the Health Plan's Service Area.

7.02.05 For Discontinuance of Health Plan. If UnitedHealthcare determines that it shall cease offering the Health Plan described in this Agreement, UnitedHealthcare may terminate this Agreement upon ninety (90) days written notice to the Director of Managed Health Care, the Group and all Members covered under this Health Plan. UnitedHealthcare shall make available to the Group all other health plans offered to new group business. In offering the option of other health plans, UnitedHealthcare shall act

uniformly without regard to the claims experience of the Group or any health-status related factor relating to Members, Eligible Employees or their eligible Dependents.

7.02.06 For Discontinuance of All New or Existing Health Plans. If UnitedHealthcare determines that it shall cease offering existing or new health plans in the group market in the State of California, UnitedHealthcare may terminate this Agreement upon one hundred eighty (180) days written notice to the Director of the Department of Managed Health Care and to the Group and all Members covered under this Health Plan.

7.03 Return of Prepayment Premium Fees Following Termination. In the event of termination by either UnitedHealthcare (except in the case of fraud or deception in the use of UnitedHealthcare services or facilities, or knowingly permitting such fraud or deception by another) or Group, UnitedHealthcare will, within thirty (30) days, return to Group the pro-rata portion of money paid to UnitedHealthcare which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to UnitedHealthcare.

7.04 Request for Review of Improper Cancellation, Rescission or Non-Renewal of Coverage.

7.04.01 Review by the California Department of Managed Health Care. The Group or Member may request a review by the California Department of Managed Health Care in the event of an alleged improper cancellation, rescission or non-renewal of this Agreement by UnitedHealthcare. The California Department of Managed Health Care shall notify UnitedHealthcare or Member if a proper complaint exists. UnitedHealthcare will reinstate coverage if the California Department of Managed Health Care determines the cancellation, rescission or non-renewal was contrary to existing law unless UnitedHealthcare requests a hearing within 15 days of receipt of the order. If the Group or Member requests a review of UnitedHealthcare's determination to cancel, rescind or non-renew this Agreement, UnitedHealthcare will continue to provide coverage to the Member under the terms of this Agreement until a final determination is made by the California Department of Managed Health Care. This provision does not apply to termination due to non-payment of Health Plan Premiums pursuant to section 7.02.01.

7.04.02 Reinstatement Following Determination of Improper Cancellation, Rescission or Non-Renewal of Coverage. In the event the California Department of Managed Health Care determines UnitedHealthcare improperly canceled, rescinded or non-renewed this Agreement or a Member's coverage under the Health Plan, UnitedHealthcare will reinstate this Agreement or the Member's coverage under the Health Plan as though it had never been terminated. UnitedHealthcare will reimburse the Member within 30 days of receipt of a completed claim for any expenses incurred for covered services, as set forth in the Combined Evidence of Coverage and Disclosure Form, the Schedule of Benefits, and the Schedule of Supplemental Benefits. This provision does not apply to termination due to non-payment of Health Plan Premiums

pursuant to section 7.02.01.

8. MISCELLANEOUS PROVISIONS

8.01 Governing Law. This Agreement is subject to the laws of the State of California and the United States of America, including the Knox-Keene Health Care Service Plan Act of 1974, as amended, (codified at Chapter 2.2 of Division 2 of the California Health and Safety Code), and the regulations promulgated thereunder by the California Department of Managed Health Care (codified at Chapter 1 of Division 1 of Title 28 of the California Code of Regulations); the Health Maintenance Organization Act of 1973, as amended, (codified at Subchapter XI of Chapter 6A of Title 42 of the United States Code), and the regulations promulgated thereunder by the Center for Medicare and Medicaid Services (codified at Part 417 of Chapter IV of Title 42 of the Code of Federal Regulations); and, the Employee Retirement Income Security Act of 1974, as amended, (codified at Chapter 18 of Title 29 of the United States Code, and the regulations promulgated thereunder by the United States Department of Labor (codified at Chapter XXV of Title 29 of the Code of Federal Regulations), and the Health Insurance Portability and Accountability Act of 1996, Public law 104-1910 (codified at Section 8.1, title II subtitle F section 261-264) and the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder. Any provisions required to be in this Agreement by any of the above laws and regulations shall bind UnitedHealthcare, Group and Member whether or not expressly provided in this Agreement.

8.02 UnitedHealthcare Names, Logos and Service Marks. UnitedHealthcare reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. Group shall not use UnitedHealthcare's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of UnitedHealthcare.

8.03 Assignment. This Agreement and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party. Notwithstanding the above, if UnitedHealthcare assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm or person, with or without recourse, this Agreement will continue in full force and effect as if such corporation, firm or person were a party to this Agreement, provided such corporation, firm or person continues to provide prepaid health services.

8.04 Validity. The unenforceability or invalidity of any part of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

8.05 Confidentiality. UnitedHealthcare agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all

applicable state and federal laws. However, Member authorizes the release of information and access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to UnitedHealthcare, its agents and employees, Member's participating medical group, and appropriate governmental agencies. UnitedHealthcare shall not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received covered services, unless authorized to do so by the Member.

8.06 Amendments. This Agreement may be modified by UnitedHealthcare as set forth in Section 3.07, above, or it may be amended upon the mutual written consent of the parties.

8.07 Attachments. The Cover Sheet and Attachments to this Agreement, and all terms and conditions set forth therein, as they are from time-to-time amended by parties, are incorporated by reference herein and made an integral part of this Agreement.

8.08 Use of Gender. The use of masculine gender in this Agreement includes the feminine gender and the singular includes the plural.

8.9 Waiver of Default. The waiver by UnitedHealthcare of any one or more defaults by Group or Member shall not be construed as a waiver of any other or future defaults under the same or different terms, conditions or covenants contained in this Agreement.

8.10 Notices. Any notice required or permitted under this Agreement shall be in writing and either delivered personally or by regular, registered, or certified mail, U.S. Postal Service Express Mail, or overnight courier, postage prepaid, or by facsimile transmission at the addresses set forth below:

If to UnitedHealthcare: UnitedHealthcare of California
Attention: President
P.O. Box 6006
Cypress, California 90630-0006

If to Group or Member, at Group's or Member's last address known to UnitedHealthcare.

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given forty-eight (48) hours after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United State Postal Service or courier. If any notice is transmitted by facsimile

transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

8.11 Acceptance of Agreement. Group may accept this Agreement either by execution of the Agreement or by making its initial payment to UnitedHealthcare of Health Plan Premiums on or before the due date specified on the Cover Sheet. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the Enrollment form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on UnitedHealthcare, Group and Members.

8.12 Entire Agreement. This Agreement, including all exhibits, attachments and amendments, contains the entire understanding of Group and UnitedHealthcare with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations, or communications, whether written or oral, between Group and UnitedHealthcare with respect to the subject matter of this Agreement.

8.13 Contracting Provider Termination. UnitedHealthcare will provide written notice to Group within a reasonable time if it receives notice that any contracting provider terminates or breaches its contract with UnitedHealthcare, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect Group.

8.14 Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly, or by implication, limit or define or extend the specific terms of the section so designated.

8.15 No Third Party Beneficiaries. Except as otherwise expressly indicated in this Agreement, this Agreement shall not create any rights in any third parties who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

8.16 Time Limit on Certain Defenses. Pursuant to Section 7.02.03 above, UnitedHealthcare shall not rescind this Agreement, terminate coverage, or increase Health Plan Premiums due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Agreement. In the event that UnitedHealthcare does not terminate coverage or rescind this Agreement due to fraud or an intentional misrepresentation of a material fact, UnitedHealthcare may increase Health Plan Premiums retroactive to the original effective date of this Agreement as described in the Group Enrollment form.

9. ARBITRATION

9.01 Disputes Between Group and UnitedHealthcare. All disputes between Group and UnitedHealthcare shall be resolved by binding arbitration before JAMS, a non-judicial arbitration and mediation service. If the amount at issue is less than $200,000, then the arbitrator will have no jurisdiction to award more than $200,000. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time a demand for arbitration is made will be applied to the arbitration. The parties will seek to mutually agree on the appointment of an arbitrator; however, if an agreement cannot be reached within thirty (30) days following the date demanding arbitration, the parties will use the arbitrator appointment procedures in the Rules. Arbitration hearings will be held at the neutral administrator's offices in Orange County, California or at another location agreed upon in writing by the parties. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected will have the power to control the timing, scope and manner of the taking of discovery and will have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California. This includes, but is not limited to, the imposition of sanctions. The arbitrator(s) will have the power to grant all remedies provided by California law. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. The parties will divide equally the fees and expenses of the arbitrator(s) and the neutral administrator. The arbitrator(s) will not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, will also apply to the arbitration.

9.02 Disputes Between Member and UnitedHealthcare.

9.02.01 Member Appeals and Grievances. The attached UnitedHealthcare Combined Evidence of Coverage and Disclosure Form includes a complete description of the UnitedHealthcare appeals and grievance procedures and dispute resolution processes for Members.

9.02.02 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 UnitedHealthcare 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 as California law provides for judicial review of arbitration proceedings. Member and UnitedHealthcare 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, 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 thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules 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, 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. 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 Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

9.03 Mandatory Arbitration. Group, Member and UnitedHealthcare agree and understand that any and all disputes, including claims of 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), except for claims subject to ERISA, shall be determined by submission to binding arbitration in accordance with the terms of this Agreement. 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. Group, Member, and UnitedHealthcare are giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in _____, California, on _____, 20___.

GROUP: _____

BY: _____

NAME: _____

TITLE: _____

DATE: _____

UHC OF CALIFORNIA
dba UnitedHealthcare of California

BY: _____

NAME: Robert C Falkenberg

TITLE: Health Plan CEO

DATE: _____

CALIFORNIA

UnitedHealthcare of California

Combined Evidence of Coverage and Disclosure Form (HMO)
Large Business Plans

July 1, 2020

Welcome to UnitedHealthcare of California

UnitedHealthcare of California ("UnitedHealthcare" or "the Plan") 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 Benefits and Acupuncture Schedule of Benefits, if purchased,*
- 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,
- 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 routine non-emergent/urgent services through your Network Medical Group shown on your identification (ID) card. 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 our Customer Service department. You can also find an online version of the 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 our Customer Service department.

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 the Department of Managed Health Care (DMHC) consumer toll-free telephone number **at 1-888-466-2219.**

What if I Still Need Help?

After you become familiar with your benefits, you may still need help. Please do not hesitate to call our Customer Service department 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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- **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 care, 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, 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 the **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 our Customer Service department. You can also find an online version of the Directory at **www.myuhc.com**.

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 our Customer Service department.

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's Customer Service department. 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 the Customer Service department 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 Customer Service department 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 our Customer Service department.

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 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 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 refer to the 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, diagnosis and treatment of an infectious, communicable or sexually transmitted disease, including HIV and HIV testing.
- Abortion

- 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 the Customer Service department at:

UnitedHealthcare Customer Service Department
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 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 toll-free number on the back of 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
Appointment for other services to diagnose or treat an injury, illness or other health condition	15 business days

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 customer service 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 the DMHC toll-free telephone number **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 Emergency Health Care Services, Urgently Needed Services, 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, you are not covered for any other medical or Hospital Services. 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** 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 our Customer Service department.

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, our Customer Service department 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 and Urgently Needed 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 the Customer Service department and request the form Request 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 our Customer Service department.

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. Covered services include those which are Medically Necessary or otherwise required to be covered under the law or otherwise as described below including those for coverage of Serious Emotional Disturbances of a Child or Severe Mental Illness. 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 the likelihood of death is probable 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.

- 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 are costs related to the provision of health care services, including drugs, items, devices and services that would otherwise be covered by UnitedHealthcare if those drugs, items, devices and services were not provided in connection with an approved clinical trial program, including:

  - Health care services typically provided absent a clinical trial.
  - Health care services required solely for the provision of the Investigational drug, item, device or service.
  - Health care services required for the clinically appropriate monitoring of the Investigational item or service.
  - Health care services provided for the prevention of complications arising from the provision of the Investigational drug, item, device or service.
  - Health care services needed for the reasonable and necessary care including the diagnosis and treatment of complications arising from the provision of the Investigational drug, item, device or service, including the diagnosis or treatment of the 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 Investigational Service, 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 and/or conflicting evidence exists regarding its effectiveness.
  - Other items and services that meet specified criteria in agreement with our medical and drug policies.
- Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that the Member may require due to the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to meet data collection and analysis needs and that is not used in the clinical management of the Member's care.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under UnitedHealthcare.
- Health care services customarily provided by the research sponsor free of charge.

With respect to cancer or other life-threatening diseases or conditions, an approved 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 that 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 by at least one of the following:
    - National Institutes of Health (NIH).
    - 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 as long as 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;
- The subject or purpose of the trial must be the review of an item or service that meets the definition of Covered Health Care Service and is not otherwise excluded under the *Agreement*.

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

All services must have prior authorized by 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 (5) 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 Disorders, are covered under this Health Plan and are provided to you by USBHPC. Mental health services for the diagnosis and treatment of Mental Disorders, including but not limited to, Severe Mental Illness (SMI) and Serious Emotional Disturbances of Child (SED) conditions, and Medically Necessary Behavioral Health Treatment administered by qualified autism service provider, or a qualified autism service professional supervised by a qualified autism service provider, or a qualified autism service paraprofessional supervised by a qualified autism service provider or a qualified autism service professional.

   - 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.

The scope of treatment services for mental health conditions that a plan must cover varies depending on whether the condition is defined as a Severe Mental Illness (SMI), a Serious Emotional Disturbances of a Child (SED), or another type of mental or substance use disorder that is not an SMI or SED. Notwithstanding any exclusions or limitations described in this EOC, all treatment services for an SMI or SED mental health condition shall be covered if and when medically necessary.

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.

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 Disorders and Substance-Related and Addictive Disorders are covered. (For a description of coverage of Mental 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 including Transitional Recovery Services Rendered at a Treatment Center** – 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.

The scope of treatment services for mental health conditions that a plan must cover varies depending on whether the condition is defined as a Severe Mental Illness (SMI), a Serious Emotional Disturbances of a Child (SED), or another type of mental or substance use disorder that is not an SMI or SED. Notwithstanding any exclusions or limitations described in this EOC, all treatment services for an SMI or SED mental health condition shall be covered if and when medically necessary.

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.

Coverage for Substance-Related and Addictive Disorder Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. See your Schedule of Benefits for Substance-Related and Addictive Disorder Services for coverage, if any, and 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 our Customer Service department 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. Covered services include those which are Medically Necessary, or otherwise required to be covered under the law or otherwise as described below including those for coverage of Serious Emotional Disturbances of a Child or Severe Mental Illness. 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. **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.
2. **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.
3. **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.
4. **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. Coverage for Outpatient prescribed drugs is only available if the Subscriber's Employer Group has purchased the supplemental Outpatient Prescription Drug Benefit. 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.
5. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
6. **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 non-implantable 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".

7. **Chiropractic Services –** Please refer to your *Chiropractic Schedule of Benefits*, if any.
8. **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.
9. **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.
10. **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".
11. **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.)
12. **Dental Treatment Anesthesia** – See Oral Surgery and Dental Services; Dental Treatment Anesthesia.

13. **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.

14. **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 a 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.

15. **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.

16. **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 if purchased as a supplemental 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 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 accommodate the Member's condition.

For a detailed listing of covered DME, please contact the 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.

17. **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 at the applicable prescription drug tier will apply.

18. **Footwear** – Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease 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.

19. **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**.

20. **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 the Customer Service department at 1-800-624-8822, or visit the UnitedHealthcare website.

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.

21. **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.

    Non-implantable hearing aid benefit will be limited to one hearing aid including repairs and replacements per hearing impaired ear every 3 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.

22. **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; and

    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 Service 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.

Please refer to the *Schedule of Benefits* for any applicable Co-payments and benefit limitations.

23. **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 5 consecutive days at a time.

24. **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.

25. **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 Services 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.

26. **Laboratory Services** – Medically Necessary diagnostic and therapeutic laboratory services are covered.

27. **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.

28. **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.

29. **Mental Health Care Services** – Services to diagnose and treat Mental Disorders and Medically Necessary Behavioral Health Treatment including but not limited to those listed below are covered under this Health Plan and are provided to you by USBHPC.

    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 Outpatient Electro-Convulsive Treatment, Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment; Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavior 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 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.

    - Behavioral Health Treatment for Pervasive Developmental Disorder ("PDD") or Autism - Prior authorization required; 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 Covered Person with pervasive developmental disorder or autism, and that meet the criteria required by California law. Please refer to **Section 10, Definitions**, for a description of the required criteria.
    - Intensive Psychiatric Treatment Programs – when provided at a Network Facility or Day Treatment Center, prior authorization 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

Prescribed medications are covered as described in the *Outpatient Prescription Drug Benefit* supplement to this *Combined Evidence of Coverage and Disclosure Form*.

The scope of treatment services for mental health conditions that a plan must cover varies depending on whether the condition is defined as a Severe Mental Illness (SMI), a Serious Emotional Disturbances of a Child (SED), or another type of mental or substance use disorder that is not an SMI or SED. Notwithstanding any exclusions or limitations described in this EOC, all treatment services for an SMI or SED mental health condition shall be covered if and when medically necessary.

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 including Co-payments and Deductibles you may have to pay.

30. **OB/GYN Physician Care** – See “Physician OB/GYN Care.”
31. **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” procedure.
  - 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. 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."

32. **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 7 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.

33. **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 pervasive developmental disorder or autism.
    - 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 pervasive developmental disorder or autism are described under Inpatient Mental Health Care Services and Outpatient Mental Health Care Services.

34. **Outpatient Rehabilitation Services and Devices** - Services include:

    - Individual and group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism.
    - 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 pervasive developmental disorder or autism are described under Inpatient Mental Health Care Services and Outpatient Mental Health Care Services.

35. **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.

36. **Outpatient Surgery** – Short-stay, same-day or other similar outpatient surgery facilities and professional Physician/ surgeon fees and outpatient visits are covered.

37. **Phenylketonuria (PKU) Testing and Treatment** – Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a result of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Network Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who takes part in or is authorized by UnitedHealthcare, provided that the diet is deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than one gram of protein per serving.
38. **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.
39. **Physician OB/GYN Care** – The Member may obtain 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.
40. **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); FDA-approved contraceptive methods and counseling; breastfeeding support and counseling; breast pump purchase of personal pump and supplies; and screening and counseling for interpersonal and domestic violence.

    Preventive screening services include but are not limited to the following:

    - **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.

- **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:
    - Five 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.

41. **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.

42. **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.)
43. **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.
44. **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.
45. **Substance-Related and Addictive Disorder Services –** Services to treat Substance-Related and Addictive Disorder, including but not limited to those listed below, are covered under this Health Plan and are provided by USBHPC.
    - 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: Outpatient evaluation and treatment for chemical dependency

- day treatment programs including partial hospitalization
- intensive outpatient programs
- individual and group Substance-Related and Addictive Disorder counseling, and
- Medical Detoxification

- 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.*

The scope of treatment services for mental health conditions that a plan must cover varies depending on whether the condition is defined as a Severe Mental Illness (SMI), a Serious Emotional Disturbances of a Child (SED), or another type of mental or substance use disorder that is not an SMI or SED. Notwithstanding any exclusions or limitations described in this EOC, all treatment services for an SMI or SED mental health condition shall be covered if and when medically necessary.

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.

Please refer to the *Schedule of Benefits* for coverage, if any. Coverage for Substance-Related and Addictive Disorder Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. See your *Schedule of Benefits* for Substance-Related and Addictive Disorder Services for any amounts you may have to pay.

46. **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.
47. **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.
48. **Telehealth Services** – Benefits are available for Covered Health Care Services received through Telehealth. No in-person contact is required between a licensed health care Provider and a Member before payment is made for Covered Health Care Services appropriately provided through Telehealth, subject to all terms and conditions under the Health Plan.

    Prior to the delivery of Covered Health Care Services via Telehealth, the health care Provider at the originating site shall verbally inform the Member that Telehealth may be used and obtain verbal consent from the Member for this use. The verbal consent shall be documented in the Member's medical record.

UnitedHealthcare will 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 health care Provider according to his or her arrangement with UnitedHealthcare.

49. **Virtual Visits** – Virtual Visits include the diagnosis and treatment of low acuity medical conditions for Members through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health Specialist, through use of interactive audio and video communications equipment 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 in the brochure by going to www.myuhc.com or see your employer to obtain a copy of the brochure or by calling Customer Care at the telephone number on your ID card.

    Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

    Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/ telemedicine visits that occur within medical facilities (CMS defined originating facilities).

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 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. **Acupuncture and Acupressure** – Acupuncture and acupressure are not covered. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED). (Coverage for acupuncture and acupressure may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's Health Plan includes acupuncture and acupressure supplemental benefit, a brochure describing it will be enclosed with these materials.)
2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
3. **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.
4. **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**.

5. **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).

6. **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 pervasive developmental disorders (PDD) or Autism.

7. **Biofeedback** – Biofeedback services are not covered except when Medically Necessary for the treatment of urinary incontinence, fecal incontinence or constipation for Member with organic neuromuscular impairment and part of an authorized treatment plan.

8. **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.

9. **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.

10. **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**.)

11. **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.
12. **Chiropractic Care** – Care and treatment provided by a chiropractor are not covered. (Coverage for chiropractic care may be available if purchased by the Subscriber's employer as a supplemental benefit. If your Health Plan includes a chiropractic care supplemental benefit, a brochure describing it will be enclosed with these materials.)
13. **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.
14. **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.")
15. **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.
16. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice facility incident to a 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. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).
17. **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.)
18. **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.

19. **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.
20. **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.
21. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your Health Plan includes a supplemental benefit, a brochure will be enclosed with these materials. Infusion drugs, infusion therapy, and prescribed contraceptive drugs required by Federal law are not considered Outpatient drugs for the purposes of this exclusion. Refer to "Injectable Drugs", "Family Planning" and "Infusion Therapy" in the outpatient benefits section for benefit coverage. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.
22. **Durable Medical Equipment** – 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.
23. **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 impediments;
- Teaching how to read, whether or not the Member has dyslexia;
- Educational testing;
- Teaching (or any other items or services related to) 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 supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply to authorized Medically Necessary services to treat autism spectrum disorders or pervasive developmental disorders or any other Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).

24. **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.
25. **Enteral Feeding** – Enteral Feedings (food and formula) and the accessories and supplies are not covered. Formulas and special food products for phenylketonuria (PKU) are covered as described under the outpatient benefit captioned “Phenylketonuria (PKU) Testing and Treatment.” Pumps and tubing are covered under the “DME” outpatient benefit. This exclusion does not apply to authorized Medically Necessary services to treat a Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).
26. **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.
27. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or investigational procedures, items and treatments are not covered unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a UnitedHealthcare Medical Director, or his or her designee. For the purposes 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 is met:
    - It cannot lawfully be marketed without the approval of the U.S. 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 application on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official documents issued by the FDA and Department of Health and Human Services (DHHS).

- It is being provided according 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.
- 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 according to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

The sources of information to be relied upon by 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."

28. **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.
29. **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.
30. **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.

31. **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.

32. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. (Coverage for specialized footwear for foot disfigurement may be available if the Subscriber's employer purchased a footwear supplemental benefit. If your Health Plan includes a footwear supplemental benefit, a brochure describing it will be enclosed with these materials.) Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Network Medical Group or UnitedHealthcare.

33. **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.

34. **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.

35. **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.

36. **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.

37. **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.

38. **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.

39. **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.

40. **Infertility Reversal** – Reversals of sterilization procedures are not covered.

41. **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, except Medically Necessary iatrogenic infertility preservation, sperm or sperm bank charges 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.

42. **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.

43. **Maternity Care, Tests and Procedures** – Elective home deliveries are not covered. Educational courses or child care and/or prepared childbirth classes are not covered.

44. **Mental Health and Nervous Disorders** – Mental health care 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.)

45. **Non-Physician Health Care Practitioners** – This Health Plan may not cover services of all Non-Physician Health Care Practitioners except as may be Medically Necessary for the treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child. 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 Care Services.)

46. **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.

47. **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.

48. **Nutritional Supplements or Formulas** – Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the outpatient description of Phenylketonuria (PKU) Testing and Treatment or Enteral and Parenteral Nutrition. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).

49. **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.

50. **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.

51. **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.)

52. **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.

53. **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**.

54. **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.

55. **Phenylketonuria (PKU) Testing and Treatment** – Food products naturally low in protein are not covered.

56. **Physical or Psychological Examinations** – 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. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED). (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.)

57. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during Inpatient Hospitalization are not covered.

58. **Prosthetics and Corrective Appliances/Non-Foot 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.

59. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by a UnitedHealthcare Medical Director or designee.
60. **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.
61. **Recreational, Lifestyle, or Hypnotic Services** – Recreational, lifestyle, or hypnotic services, and related testing are not covered except as provided in this paragraph. Recreational therapy services are only covered when they are authorized, part of a Medically Necessary treatment plan, provided by an authorized provider who is a registered physical, speech or occupational therapist or a health care professional under the supervision of a licensed physical therapist acting within the scope of his or her license or as authorized under California law or as Medically Necessary for the treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child. See "Inpatient Rehabilitation Care" under "Inpatient Benefits" and Outpatient Medical Rehabilitation and Habilitation Therapy under "Outpatient Benefits" for an explanation of coverage of physical, occupational and speech therapy.
62. **Rehabilitation Services and Therapy** – Rehabilitation 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 and are either limited or not covered as listed below. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).
    - 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, pervasive developmental disorders and autism.
    - 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 Rehabilitation Services, special evaluations and therapies are not covered:

- Biofeedback (except when Medically Necessary for the treatment of urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.)
- 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.

(Please refer to **Section 10** for definitions of capitalized terms.)

63. **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.
64. **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.
65. **Reversal of genital surgery or reversal of surgery** – Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics is not covered.
66. **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.
67. **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.
68. **Sperm preservation in advance of hormone treatment or gender surgery**
69. **Substance-Related and Addictive Disorder** Services – Substance-Related and Addictive Disorder Services are not covered unless purchased by the subscriber's employer as a supplemental benefit. See **Section 5. Your Medical Benefits**, for a description of coverage, if any.
70. **Surgical or cross-gender hormone treatment for Members under 18 years of age is reviewed on a case-by-case basis by UnitedHealthcare.**
71. **Surgical treatment not prior authorized by UnitedHealthcare or designee**
72. **Surrogacy** – Infertility and maternity services for non-Members are not covered.
73. **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.
74. **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.

75. **Treatment received outside the United States –** Surgery or non-surgical treatment for gender dysphoria performed outside of the United States is not covered.
76. **Vision Care** – See “Eyewear and Corrective Refractive Procedures” listed in “Other Exclusions and Limitations.”
77. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
78. **Visual Aids** – Visual aids are not covered, except as shown under the outpatient benefit for Diabetic Self-Management Items. Electronic and non-electronic magnification devices are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit.)
79. **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 non-authorized weight loss program laboratory tests related to monitoring weight loss or weight gain, except as described under inpatient benefits Morbid Obesity (Surgical Treatment). This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED). For further information on benefits, please refer to **Section 5: Your Medical Benefits** and to the behavioral health supplement of your *Combined Evidence of Coverage and Disclosure Form* for USBHPC under Mental Disorders to treat SMI/ SED conditions.

    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**.

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: Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health, prescription drugs and, if purchased, acupuncture benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups.

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.

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: non-group coverage of any type, including, but not limited to, individual or family insurance; 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.

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 an Employer Group that you are actively working at, and you are enrolled in Medicare, the group health 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 and enrolled in a health plan with less than 100 eligible employees; or
3. Members who are entitled to Medicare due to End Stage Renal Disease (ESRD) after the mandated 18-month period.

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.

SECTION 7. MEMBER ELIGIBILITY

- **Who is a UnitedHealthcare Member? Requirements**
- **Adding Family Members**
- **Late Enrollment**
- **Updating Your Enrollment Information**
- **Termination of Enrollment**
- **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 benefits 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 furnished 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 pursuant to a qualified medical child support order assignment order, or medical support order, in this section.

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 as a result of 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 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, medical review questionnaires 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 Open Enrollment

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 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. 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 benefits plan. An Open Enrollment Period usually occurs once a year, 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 Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the Employer Group stops contributing toward your or your Dependents' other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents during a special enrollment period. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period. To obtain more information, contact 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 as a result of marriage within 30 days of the marriage.

2. **Domestic Partnership.** When a new Domestic partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Having a Baby**. Newborns are covered from the moment of birth for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, an application or Change Request Form must be submitted to UnitedHealthcare within 31 days to add the newborn child. If you do not enroll the newborn child during the special enrollment period, 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 30 days of the adoption placement.
5. **Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's legal spouse or Domestic Partner has assumed legal guardianship, the Subscriber must submit a Change Request Form to UnitedHealthcare along with a certified copy of a court order granting guardianship within 30 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.

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 restrictions.

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 UnitedHealthcare's 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 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 selected 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 the Employer Group may extend their coverage under the following circumstances:

A Dependent residing outside of the Service Area must maintain a permanent address inside the Service Area and must select 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 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 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; and
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 demonstrate that he or she meets the requirements for late enrollment.
3. The other health care coverage is no longer available due to:
    a. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or
    b. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
    c. The termination of the other Health Plan coverage; or
    d. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or

e. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered;

f. The loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage; or

g. The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or

h. 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

i. 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. 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.

If the employee or an eligible Family Member meets these conditions, the employee must request enrollment with UnitedHealthcare no later than 30 days following the termination of the other Health Plan coverage. UnitedHealthcare may require proof of loss of the other coverage, except for Dependent child special enrollment period. Enrollment will be effective on the date agreed to by the Employer Group under the terms of the signed Group Agreement or the first day of the month following receipt by UnitedHealthcare of a completed request for enrollment. This paragraph does not apply to the Dependent Child Special Enrollment Period.

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 modify 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 modification. 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 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 contact UnitedHealthcare's Customer Service department at 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 employees who are UnitedHealthcare Members of any such amendment or modification.

About Your UnitedHealthcare Health Plan 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 immediately terminate that Member's membership.

Termination of Benefits

Usually, your enrollment in UnitedHealthcare terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health benefits plan. In most instances, 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 begins after 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. In that circumstance, UnitedHealthcare will notify you directly of such termination.

Termination and Rescission of 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 failed to pay the required Premiums. UnitedHealthcare will mail your Employer a notice at least 30 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the Premiums due within 30 days of the date the notice was mailed.

If payment is not received from your employer within 30 days of the date the Prospective Notice of Cancellation is mailed, UnitedHealthcare will cancel the Group contract and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Group contract has been cancelled for nonpayment of Premiums.
- The specific date and time when your Group coverage ended.
- The Plan telephone number you can call to obtain additional information, including whether your Employer obtained reinstatement of the Group contract. This confirmation of reinstatement will be available on request 16 days after the date the Notice Confirming Termination of Coverage is mailed.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date the Plan mails you the Notice Confirming Termination of 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 30 days of the date of the Notice Confirming Termination.

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: (1) the date of the Group Agreement; or (2) 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).

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, contact 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's 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 the employer 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.

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 (Individual Continuation of Benefits)

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 legal 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 Subscriber becomes 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 occurred. 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 occurs. 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 occurred, 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 (36 months minus eight months). 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 maximum 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 maximum 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 occurred.

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 Maximum Coverage Period Ends

Under COBRA, the continuation coverage may terminate before the maximum coverage period if any of the following events occur:

1. Your Employer Group no longer provides group health coverage to any of its 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. Premium 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.

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 do not 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 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 on 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 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 do not make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her 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 as a result of 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.

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. 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 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 preexisting conditions. Please contact Member Service for information on how to apply for reinstatement of coverage following active duty as a reservist.

SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

- **How UnitedHealthcare Makes Important Decisions?**
- **What to Do if You Have a Problem?**
- **Filing a Grievance**
- **Appeals and Grievances Process**
- **Independent Medical Reviews**

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 plan, including how to appeal a health care decision by UnitedHealthcare or one of our Network Providers. You'll 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 UnitedHealthcare Makes Important Health Care Decisions?

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may be conducted 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 detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered 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 frames because (i) UnitedHealthcare, or in many situations the Network Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii consultation by an expert reviewer is required, or (iii) the reviewer 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, 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 UnitedHealthcare or the Network Medical Group becomes aware that they 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 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 UnitedHealthcare, or in many situations the Network Medical Group, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

The reviewer will notify requesting Providers initially by fax or telephone 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, delay or modify requested health care services, in writing, within two business days of the decision. The written decision to the Member 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 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 individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage 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 efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Co-payments, 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 efficacy 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, delay 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.

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 assist 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
Mail Stop CA124-0160
Cypress, CA 90630-9972

This request will begin the 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 email 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 necessary, 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 accordance with state law.

After participating in UnitedHealthcare's grievance process 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 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.

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 calling our Customer Service department at 1-800-624-8822 or 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 toll-free telephone number at **(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 **1-800-735-2929 or 1-888-877-5378 (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.

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.

To begin an appeal, call 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 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 **1-800-735-2929 or 1-888-877-5378 (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 contracting 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 initiate 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 rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. 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 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 has 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 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 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: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (b) 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. Either (a) 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 (b) 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 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 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 rendered by non-contracting 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 pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered 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 preaddressed envelope to be used to request IMR from the DMHC.

Disputed Health Care Services

You may also request IMR of a Disputed Health Care Service. A Disputed Health Care Service is any health care service eligible for coverage and payment under your Health Plan that has been denied, modified or delayed by UnitedHealthcare or one of its Network Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (**Note:** Disputed Health Care 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 if you meet all of the following criteria:

1. (a) Your Provider has recommended a health care service as Medically Necessary; or (b) you have received Urgently Needed Services or Emergency Health Care Services that a Provider determined were Medically Necessary; or (c) 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 has 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 and the disputed decision is upheld or the appeal remains unresolved after 30 days (or three 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 participate in the appeals process for at least 30 calendar days if the DMHC determines that an earlier review is necessary.)

You may apply to the DMHC for IMR of a Disputed Health Care Service 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 health care services based in whole or in part due to a finding that the service is not Medically Necessary. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against UnitedHealthcare regarding the Disputed Health Care Service. 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 its notice to you that the requested service has been denied and include a Physician certification form with a preaddressed 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 is 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 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 was 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 reach the DMHC by calling 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 selects 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 needed 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 an annotated 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 Non-PDL/ Formulary Drugs

If a Member objects to a disapproval of a prior authorization request of a "non-PDL/ formulary" 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 render 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 not promptly initiated. 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 has 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 rendered 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 Service denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical 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 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, 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 secure 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 were a covered benefit 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 UnitedHealthcare's Customer Service department.

Complaints Against Network Medical Groups, Providers, Physicians and Hospitals

Claims against a Network Medical Group, the group's Physicians, or Providers, Physicians 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, ancestry, 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 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.*

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.

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*.)

Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or Autism - 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 pervasive developmental disorder or autism, 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 by the Network 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 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 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.

3. **A pregnancy -** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Health Care Services will be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

   Maternal Mental Health Condition. A mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. The member's current Provider shall provide written documentation of a Maternal Mental Health Condition diagnosis from the member's treating health care Provider. Completion of Covered Services will be provided not to exceed 12 months from the diagnosis of the Maternal Mental Health Condition, or from the end of pregnancy, whichever occurs later, and to arrange for a safe transfer to a provider. The transfer shall be determined by UnitedHealthcare in consultation with the member and the terminated provider and consistent with good medical practice.

4. **A Terminal Illness** – An incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Health Care Services will be provided for the duration of the terminal illness.

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.

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 cost of the 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.

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 if the amount incurred 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 via interactive audio and video modalities

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 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.
    - 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 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 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 disorder.

Emergency Health Care Services – 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 relieve 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 necessary to relieve or eliminate a Psychiatric Emergency Medical Condition. (For a detailed explanation of Emergency Health Care Services, see **Section 3. Emergency and Urgently Needed Services**.)

Employer Group – The single employer, labor union, trust, organization or association through which you enrolled for coverage.

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 (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four (4) hours of Home Health Aide Services.

Hospice – 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.

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.

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 Disorder – A mental health condition identified as a "mental health disorder" in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in clinically significant distress or impairment of mental, emotional or behavioral functioning. Mental Disorders include the Severe Mental Illness of a Person of Any Age and the Serious Emotional Disturbances of a Child as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental Health Care Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders, including but not limited to Severe Mental Illness and Serious Emotional Disturbances of a Child. Substance-Related and Addictive Disorder Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit.

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. Network Medical Groups are independent contractors and are not employees of UnitedHealthcare.

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 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 pervasive developmental disorder or autism, 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 pervasive developmental disorder or autism, 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.
- 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 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.
- 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 and Intensive Outpatient Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program 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.

Physician – Any licensed allopathic or osteopathic Physician. It includes a licensed acupuncturist.

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 – 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.

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 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.

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 maximum extent practical the functioning of individuals.

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.

Serious Emotional Disturbances of a Child – (SED) Under Age 18 – A Serious Emotional Disturbances 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 one of the following: 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.

Severe Mental Illness – Severe Mental Illness (SMI) includes the diagnosis and Medically Necessary treatment of the following conditions:

- Anorexia nervosa;
- Bipolar disorder—manic depressive illness;
- Bulimia nervosa;
- Major depressive disorder;
- Obsessive-compulsive disorder;
- Panic disorder;
- Pervasive developmental disorder or autism;
- Schizoaffective disorder;
- Schizophrenia.

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 – 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.

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. 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.

UnitedHealthcare-Designated Pharmacy – UnitedHealthcare Network pharmacy designated to dispense injectable medications. A UnitedHealthcare-Designated Pharmacy may include Prescription Solutions® Mail Service Pharmacy or alternative specialty injectable vendor as determined by UnitedHealthcare.

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 needed, 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 needed, 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.

Effective 7/01/2020

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PCA846328-000

SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits

30/750A

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Family Out-of-Pocket Limit.	Individual $1,500 Family $3,000
PCP Office Visits	$30 Office Visit Co-payment
Specialist Office Visits (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$30 Office Visit Co-payment
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment)	$750 Co-payment per admit
Emergency Services	$150 Co-payment (Co-payment waived if admitted)
Urgently Needed Services Urgent care services – services provided **within** the geographic area served by your medical group Urgent care services – services provided **outside** of the geographic area served by your medical group Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	$30 Co-payment $30 Co-payment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$750 Co-payment per admit
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 Participating 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 Participating Providers, in addition to any applicable Co-payments, coinsurance 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)	$750 Co-payment per admit
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment)	$750 Co-payment per admit
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$750 Co-payment per admit
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 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.	$750 Co-payment per admit
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.)** (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment)	$600 Co-payment per admit
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.	$750 Co-payment per admit
Physician Care	No charge
Reconstructive Surgery	$750 Co-payment per admit
Rehabilitation Care (Including physical, occupational and speech therapy)	$700 Co-payment per admit
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child Inpatient and Residential Treatment Unlimited days **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	$600 Co-payment per admit
Skilled Nursing Facility Care (Up to 100 days per benefit period)	No charge
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.**	No charge
Termination of Pregnancy (Medical/medication and surgical)	$125 Co-payment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	$30 Office Visit Co-payment
Specialist Office Visit	$30 Office Visit Co-payment
Ambulance	No charge
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 Participating 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 Participating Providers, in addition to any applicable Co-payments, coinsurance 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 therapy may apply) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$30 Co-payment per item
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	$30 Co-payment
Dialysis (Physician office visit Co-payment may apply)	$30 Co-payment per treatment
Durable Medical Equipment	No charge
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
Family Planning (Non-Preventive Care)	
Vasectomy	$50 Co-payment
Depo-Provera Injection – (other than contraception)	
PCP Office Visit	$30 Office Visit Co-payment
Specialist Office Visit	$30 Office Visit Co-payment
Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days.)	$35 Co-payment
Termination of Pregnancy (Medical/medication and surgical)	$125 Co-payment
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 Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	
Hearing Aid - Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	No charge
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.

Benefits Available on an Outpatient Basis (Continued)

Hearing Exam	
PCP Office Visit	$30 Office Visit Co-payment
Specialist Office Visit	$30 Office Visit Co-payment
Co-payments for audiologist and podiatrist visits will be the same as for the PCP. 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.	
Home Health Care Visits (Up to 100 visits per calendar year)	$30 Co-payment per visit
For Infusion Therapy, a separate Infusion Therapy Copayment applies per 30 days	
Hospice Services	No charge
(Prognosis of life expectancy of one year or less)	
Infertility Services	Not covered
Infusion Therapy	$40 Co-payment per medication
(Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	
Injectable Drugs	$40 Co-payment per medication
Outpatient Injectable Medication	
Self-Injectable Medication	
(Co-payment/Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Co-payment/Coinsurance may also apply) 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 Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	
Laboratory Services	No charge
(When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply)	
Maternity Care, Tests and Procedures	
PCP Office Visit	No charge
Specialist Office Visit	No charge
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.	
Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of Child)	
Outpatient Office Visits include:	$30 Office Visit Co-payment
Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management	
All Other Outpatient Treatment include:	No charge
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.**)	

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$250 Co-payment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$30 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
Physician Care PCP Office Visit Specialist Office Visit	 $30 Office Visit Co-payment $30 Office Visit Co-payment
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.	No charge
Prosthetics and Corrective Appliances	No charge
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) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge No charge
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. In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge No charge
Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) **Please see outpatient “Mental Health Services” section for cost sharing and services that apply to SMI and SED. Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	

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	No charge
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.**	No charge
Virtual Visits 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 Customer Service at the telephone number on your ID card.	$25 Co-payment
Vision Refractions	$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 PARTICIPATING 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 THE 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

PCA831000-001
WUN/WUP/WUZ

ACN GROUP OF CALIFORNIA, INC.
d/b/a OPTUMHEALTH PHYSICAL HEALTH OF CALIFORNIA
GROUP ENROLLMENT AGREEMENT
COVER SHEET ("Cover Sheet")
(This cover sheet is an integral part of this Agreement)

GROUP NAME: SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP

GROUP COVERAGE EFFECTIVE DATE: January 1, 2021 through December 31, 2021

PLAN DESCRIPTION: Custom Acupuncture/Chiropractic $15/40 Visits

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**

Schedule of Benefits, OptumHealth Physical Health of California Combined Evidence of Coverage and Disclosure Form

ACN GROUP OF CALIFORNIA, INC. doing business as
OptumHealth Physical Health of California
P.O. Box 880009, San Diego, CA 92168-0009
(619) 641-7100
1-800-428-6337

GROUP ENROLLMENT AGREEMENT

By and Between

ACN GROUP OF CALIFORNIA, INC.

and

GROUP

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GROUP ENROLLMENT AGREEMENT

WITH

ACN GROUP OF CALIFORNIA, INC. doing business as OptumHealth Physical Health of California

P.O. Box 880009
San Diego, CA 92168-009
(619) 641-6700
1-800-428-6337

RECITAL

In consideration of the payment of premiums in accordance with the terms and conditions of this Group Enrollment Agreement and all of its attachments (hereinafter collectively referred to as the "Agreement"), ACN Group of California, Inc. doing business as OptumHealth Physical Health of California (hereinafter referred to as “Health Plan”), a California corporation licensed as a Knox-Keene Health Care Service Plan, together with UHC of California dba UnitedHealth Care of California, and Employer group (hereinafter referred to as the "Group"), hereby agree that Health Plan shall provide or arrange for the provision of Chiropractic Services and Acupuncture Services (as hereinafter defined) in accordance with the terms and conditions of this Agreement to Members (as defined herein) enrolled in Health Plan’s chiropractic and acupuncture benefits program pursuant to this Agreement.

SECTION 1
DEFINITIONS

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 any given calendar 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 or treatment of Chiropractic Disorders.

1.7 Chiropractor

"Chiropractor" means an individual duly licensed to practice chiropractics in California.

1.8 Combined Evidence of Coverage and Disclosure Form

"Combined Evidence of Coverage and Disclosure Form" means a document provided to each Subscriber which summarizes the key terms and provisions of this Agreement and describes the coverage to which the Subscriber is entitled under this Agreement including, but not limited to, the principle benefits, Exclusions and Limitations applicable to such coverage. The Combined Evidence of Coverage and Disclosure Form for Chiropractic Services and Acupuncture Services is set forth as Attachment A hereto and incorporated herein by this reference.

1.9 Coordination of Benefits/COB

"Coordination of Benefits" or "COB" means those provisions of this Agreement under which Health Plan seeks to recover a portion of the cost of Covered Services from an insurer or other third party payor which also provides indemnity or other coverage for Chiropractic or Acupuncture Services provided to a Member.

1.10 Co-payment

"Co-payment" means a predetermined amount specified in the Schedule of Benefits to be paid by the Member each time a specific Covered Service is received. Co-payments are to be paid by Members directly to the Participating Provider who or which provided the Covered Service(s) to which such Co-payments apply.

1.11 Covered Services

"Covered Services" means those Medically Necessary Chiropractic Services or Acupuncture Services, including Urgent Services to which Members are entitled under this Agreement and the terms of the applicable Combined Evidence of Coverage and Disclosure Form as such documents may be amended from time to time in accordance with their terms.

1.12 Department

"Department" means the California Department of Managed Health Care.

1.13 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.

1.14 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 Domestic Partner

"Domestic Partner" is a person who meets the eligibility requirements, as defined by 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.

1.16 Exclusion

"Exclusion" means any service, equipment, supply, or accommodation specifically listed or described as excluded in this Agreement or the Combined Evidence of Coverage and Disclosure Form.

1.17 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 this Agreement, and on whose behalf Health Plan has received premiums.

1.18 Limitation

"Limitation" means any provision, other than an Exclusion, contained in this Agreement or the Schedule of Benefits, which limits the covered Chiropractic Services or Acupuncture Services to which Members are entitled.

1.19 Medically Necessary

"Medically Necessary" means:

(a) Chiropractic: Necesssary 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 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 in 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.

1.22 Negotiated Rates Schedule
"Negotiated Rates Schedule" means the schedule of rates, which the Participating Provider has agreed to accept as payment in full for Covered Services provided to Members.

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 Health Plan to provide Covered Services to Members.

1.24 Schedule of Benefits
"Schedule of Benefits" means the summary of Co-payments, Annual Benefit Maximums, Exclusions and Limitations applicable to Member’s chiropractic and acupuncture benefits program. The Schedule of Benefits is Attachment A to the 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 can not reasonably be delayed.

SECTION 2
EFFECTIVE DATE AND TERM OF AGREEMENT

This Agreement shall be effective as indicated on the Cover Sheet of this Agreement..

SECTION 3
RENEWAL PROVISIONS

After the Initial Term which is one year from the Effective Date, this 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 either party in accordance with Section 22 of this Agreement. However, Health Plan has reserved the right to change the Premium Rate Schedule in accordance with Section 5.4 of this Agreement and any other term or condition of this Agreement upon thirty-one (31) days prior written notice to the Group.

SECTION 4
IDENTIFICATION OF BENEFIT PLAN

Benefit Plan Description	Chiropractic and Acupuncture Benefit Plan, as described in Attachment B.

SECTION 5
PREPAYMENT OF FEES

5.1 Premium Rate Schedule

As indicated on and incorporated in the Cover Sheet of the UHC of California Group Subscriber Agreement.

5.2 Premium Due Date and Payments

The first day of a month of coverage hereunder is the "Premium Due Date". The Group agrees to remit to Health Plan on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section 5.1 immediately above, for each Subscriber enrolled as of such date as determined by Health Plan by reference to Health Plan Member records. If such premium payment is not made in full by the Group on or prior to the Premium Due Date, a thirty-one (31)-day grace period shall be granted to the Group for payment without interest charge.

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 due calculated for each thirty-one (31) day period or portion thereof during

which the premium remains outstanding. In addition, coverage of a Member whose premium is unpaid may be terminated by Health Plan pursuant to Section 21. Only Members for whom payment is received by Health Plan shall be eligible for Covered Services hereunder, and then only for the period covered by such payments.

If this Agreement is terminated for any reason, Group shall continue to be liable for all premium payments due and unpaid at the time of such termination, including, but not limited to, all applicable premium payments for any time the Agreement was in force during a grace period, or, at Health Plan's option, for the applicable amounts listed in the Negotiated Rates Schedule for all Covered Services by Members during the period for which premiums were not paid.

5.3 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.

5.4 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 sixty (60) 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 sixty (60) days prior written notice to the Group. 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.

5.5 Group Contribution

Group shall offer Health Plan’s benefits program to all employees of the Group on terms no less favorable with respect to the Group's contribution to the total monthly premium than those applicable to the chiropractic and acupuncture portion of any such other benefits program as may be available through the Group. Except as otherwise provided in the Agreement, Group's contribution shall not be changed during the term of this Agreement, unless such change is agreed to in writing by Health Plan. If, however, the Group's contribution attributable to the chiropractic and acupuncture health portion of any such other similar program as may be available through the Group is increased during the term of the Agreement, the Group shall promptly notify Health Plan and Group shall increase its contribution to Health Plan's health benefits program by the same amount, effective the first Premium Due Date following the increase in the Group's contribution to such other chiropractic and acupuncture benefits programs.

SECTION 6
OTHER CHARGES

Each Member is personally responsible for all Co-payments listed in the Schedule of Benefits applicable to Covered Services received by the Member. Members must pay all applicable Co-payments to the Participating Provider who provided the Covered Services to which such payments apply at the time such services are rendered.

SECTION 7
ELIGIBILITY

7.1 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:

7.1.1 Full-time employees working thirty (30) or more hours per week.

7.1.2 Family Dependents who are persons listed on an enrollment form completed by the Subscriber, and is one of the following:

7.1.2.1 The Subscriber's Domestic Partner or 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

7.1.2.2 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 law 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

7.1.2.3 A child as defined in Section 7.1.2.2 above who is, and continues to be, both incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, 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 of at least 26 years old as established by federal regulations or as amended by state or federal law or regulations, and proof of such incapacity and

dependency is furnished to Health Plan by the Subscriber within 60 days of the child's attainment of the applicable limiting age; or

(B) The physically or mentally disabling injury 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 physically or mentally disabled dependent immediately prior to the Group enrolling with Health Plan.

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 or Domestic Partner. 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

7.1.3 Eligible persons must reside in the U.S.

7.1.4 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.

7.1.5 If both parents of a dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Family Dependent.

7.2 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.

7.3 Nondiscrimination

Except as otherwise provided in this Agreement, Health Plan shall 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.

7.4 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 15.

SECTION 8
ENROLLMENT

8.1 Initial Enrollment

Members who elect enrollment through the Group are automatically enrolled for coverage under the benefit plan by the Group.

8.2 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 the 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 thirty-one (31) days of the date that coverage under the prior plan terminated. The Group shall promptly forward to Health Plan and/or medical plan a copy of each enrollment form received by the Group in accordance with this Section 8.2.

SECTION 9
MEMBER EFFECTIVE DATES OF COVERAGE

9.1 Effective Date

Subject to the Group's payment of the applicable Total Monthly Premium for each Member as set forth in Section 5.1, 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 Members first becoming eligible, coverage under this Agreement shall become effective for said Members on the effective date of coverage specified by the Group.

9.2 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 and appropriate premium is paid.

9.3 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 10
INELIGIBLE MEMBERS

If, upon a Member becoming ineligible, the Group fails to notify Health Plan of such Member's ineligibility and the Group has made or continues to make the premium payment specified herein for such Member, such premium payment(s) shall be credited by Health Plan to the Group, provided that the Group gives Health Plan notice of the ineligibility no later than thirty-one (31) days after the date eligibility ceased, and provided that Health Plan has not provided, or indemnified the Member for, Covered Services rendered to the Member after the Member's eligibility ceased and before Health Plan received notice of ineligibility.

SECTION 11
PRINCIPAL BENEFITS AND COVERAGE

Members shall be entitled under this Agreement to receive the Covered Services described under the caption "Principle Benefits and Coverages" in the Combined Evidence of Coverage and Disclosure Form set forth in Attachment A, including second opinions, subject to all applicable Exclusions and Limitations described in the Combined Evidence of Coverage and Disclosure Form, as well as all other terms and conditions contained in this Agreement. Prior to decreasing any benefits to which Members are entitled under this Agreement, Health Plan shall give at least sixty (60) days written notice to the Group in accordance with Section 23.14.

SECTION 12
PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

Members shall not be entitled under this Agreement to receive any of the services described under the caption "Principal Exclusions and Limitations of Benefits" in the Combined Evidence of Coverage and Disclosure Form set forth in Attachment A.

SECTION 13
CHOICE OF PROVIDERS

13.1 Access to Participating Provider

Each Member who requests that Covered Services be provided will be able to choose from any 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 included in the Combined Evidence of Coverage and Disclosure Form or by calling the toll-free telephone number on the back of the Member's Identification card.

13.2 Liability of Member for Payment

If a Member chooses to obtain 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, Domestic Partner, brother, sister, parent or child are not covered.**

13.3 Continuity of Care

Upon a Member's request, Health Plan shall arrange for the completion of Covered Services that are being rendered by a terminated Participating 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. Health Plan shall arrange for the completion of Covered Services in accordance with the standards and procedures described in Section 8.5 of the Combined Evidence of Coverage and Disclosure Form.

13.4 Authorizations

A summary and notice of the availability of the process the Health Plan uses to authorize, modify, or deny services under benefits provided by the Health Plan is included in the Combined Evidence of Coverage and Disclosure Form set forth in Attachment A, and will be made available to enrollees, or persons designated by an enrollee, upon request.

SECTION 14
MANAGED CARE PROGRAM

14.1 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.

14.2 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.

14.3 Appeal Rights
All decisions made by Health Plan in connection with the Managed Care Program may be appealed by the Member through the Grievance Procedures set forth in Section 20 of this Agreement.

SECTION 15
COORDINATION OF BENEFITS (COB)

15.1 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.

15.2 Benefits Subject to COB
All of the benefits provided under this Agreement are subject to COB in accordance with the provisions of this Section 15.

If a Member is eligible for Medicare on a primary basis (Medicare pays before benefits under this Agreement), Member should enroll for and maintain coverage under both Medicare Part A and Part B. If Member doesn’t enroll and maintain that coverage and if Health Plan is the secondary payor, Health Plan will pay benefits under this Agreement as if Member was covered under both Medicare Part A and Part B. In such instance, Member shall be responsible for costs that Medicare would have paid and Member will incur a larger out-of-pocket cost.

If Member is enrolled in a Medicare Advantage plan on a primary basis, Member should follow all rules of that plan that require Member to seek service from that plan's participating providers. When Health Plan is the secondary payor, Health Plan will pay benefits available to Member under this Agreement as if Member had followed all rules of the Medicare Advantage plan. Member will be responsible for any additional costs or reduced benefits that result from Member's failure to follow these rules, and Member will incur a larger out-of-pocket cost.

15.3 Definitions

The following definitions are applicable to the provisions of this Section 15 only:

"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.

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.

The term "Plan" shall include:

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.

"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.

The term "Plan" shall not include:

Individual or family policies, or individual or family subscriber contracts, except as otherwise provided herein.

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.

Medical payment benefits customarily included in traditional automobile contracts.

15.3.2 "This Plan" means that portion of this Agreement that provides the benefits that are subject to this Section 15.

15.3.3 "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.

15.3.4 "Claim Determination Period" means a calendar year.

15.4 Effect on Benefits

15.4.1 This Section 15 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:

15.4.1.1 The value of the benefits that would be provided by this Plan in the absence of this Section 15, and

15.4.1.2 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.

15.4.2 As to any Claim Determination Period to which this Section 15 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 15.4.3 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.

15.4.3 If another Plan which is involved in Section 15.4.2 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 15.5 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.

15.5 Rules Establishing Order of Determination

For the purpose of Section 15.4 immediately above, the rules establishing the order of determination are:

15.5.1 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.

15.5.2 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.

15.5.3 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.

15.5.4 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.

15.5.5 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 with respect to the child, then, notwithstanding Sections 15.5.3 and 15.5.4 immediately above, 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.

15.5.6 When rules 15.5.1 through 15.5.5 above 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:

15.5.6.1 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

15.5.6.2 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 15.5.6.1 immediately above 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.

15.6 Reduction of Benefits

When this Section 15 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.

15.7 Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section 15 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.

15.8 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.

15.9 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 15, 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 16
THIRD PARTY LIABILITY

If any Chiropractic Disorder or Acupuncture Disorder is caused by any third party and the Member has the right to recover damages from that third party, Health Plan shall provide or make payment for Covered Services. Acceptance of such Covered Services shall constitute consent by the Member to the third party liability provisions set forth in Section 12 of the Combined Evidence of Coverage and Disclosure Form.

SECTION 17
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 18
RESPONSIBILITIES OF THE GROUP

18.1 Offering Coverage

The Group shall offer Health Plan's coverage to all eligible employees and their eligible family members, and to each new employee as a procedure of employment when such person attains eligibility in accordance with the requirements of this Agreement.

18.2 Notice of Change in Coverage

The Group shall give at least sixty (60) days prior written notice to Health Plan of any intent to change health benefit coverage.

18.3 Listing of Members

The Group shall furnish to Health Plan on an at least monthly basis, in a form approved by Health Plan, a listing of all eligible Members and a listing of each Member who has been added or deleted that month, including the effective date of each such enrollment or disenrollment, and such other information as may reasonably be required by Health Plan for the administration of Health Plan's chiropractic and acupuncture benefits program. In addition, the Group shall permit Health Plan, at reasonable times, to examine the Group's pertinent records with respect to eligibility and premium payments hereunder. The Group shall also furnish to Health Plan notice of those Family Dependents described in and pursuant to Section 7.1.2.4 above, at least sixty (60) days prior to the Family Dependent reaching the limiting age of 26 or as required by state or federal law or regulations.

18.4 Dissemination of Notices, Materials and Other Information to Members

The Group shall arrange for a Group representative to serve as a liaison between the Group and Members. Such Group representative shall disseminate to Members with

the next regular written communication sent to Members, but in no event later than thirty (30) days following receipt by the Group of any notice intended for Members that is received by the Group from Health Plan pursuant to this Agreement. Such Group representative shall also disseminate to Members all applicable Combined Evidences of Coverage and Disclosure Forms, brochures, newsletters and other materials and information relating to Health Plan's chiropractic and acupuncture benefits plan when requested by Health Plan.

18.5 Indemnification

The Group shall defend, hold harmless and indemnify Health Plan from any and all claims, liabilities, damages or judgments asserted against, imposed upon, or incurred by Health Plan that arise out of the Group's negligence or intentional wrongdoing in the discharge of its responsibilities under this Agreement. The indemnification granted under this paragraph expressly includes indemnification with respect to expenses, legal fees, defense costs, court costs, or amounts paid in settlement or in satisfaction of any judgment or award.

18.6 Required Information

The Group will furnish Health Plan with all information necessary for the calculation of premium and all other information that may be reasonably required by Health Plan. Failure of the Group to furnish such information will not invalidate any insurance health plan coverage, nor will it continue any health plan coverage beyond the date of termination. Health Plan has the right to examine at any reasonable time any records of the Group, any person, health plan, or organization hired to assist in the administration of the Agreement which have a bearing on the Premiums and benefits of the Agreement.

18.7 Compensation of Health Plan

The Group shall compensate Health Plan in accordance with the Premium Rate set forth in Section 5.1 of this Agreement. In the event that Covered Services have been rendered to a Member in good faith based on eligibility information provided by Group, Group shall be liable for payment of any Covered Services rendered to the ineligible Member. Health Plan shall bill Group and payment shall be made upon receipt of the Participating Provider billing for the Covered Services rendered to the ineligible Member.

SECTION 19
RESPONSIBILITIES OF HEALTH PLAN

19.1 Arrangements for Covered Services

Health Plan shall enter into arrangements with Participating Providers in order to make available to Members the Covered Services described in the Schedule of Benefits set forth in the Combined Evidence of Coverage and Disclosure Form contained in Attachment A. Subject to Section 13.3, 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.

19.2 Compensation of Providers

Health Plan shall be responsible for compensating Participating Providers for Covered Services provided to eligible Members in accordance with the requirements of this Agreement and 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 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 the Member who received such services may be liable to the provider for the cost of the services.

19.3 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.

19.4 Combined Evidence of Coverage and Disclosure Forms

Health Plan shall provide the Group with one Combined Evidence of Coverage and Disclosure Form to provide for each Subscriber.

19.5 Summaries of Program Activities

Health Plan shall prepare and provide to the Group statistical summaries of program activities. Health Plan shall provide standard statistical summaries of program activities at no charge. Upon request of the Group and for an additional fee, Health Plan shall provide, within a time period mutually agreed to by both parties, ad hoc or non-standard specialized reporting of data regarding the services outlined in this Agreement.

19.6 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 Chair of the Public Policy Committee at the address on the cover of the Agreement for further information.

19.7 Notices to Group Representative

Any notice required to be given by Health Plan to the Group pursuant to this Agreement may be given by Health Plan to the Group representative designated by the Group.

19.8 Termination or Breach of a Provider Contract

19.8.1 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.

19.8.2 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 shall retain financial responsibility for such continuation of care in excess of any applicable Co-payments. The Co-payments during the period of continuation of care with a terminated provider shall be the same Co-payments that would be paid by the Member when receiving care from a Participating Provider. Such responsibility shall continue until the Covered Services being rendered are completed, or until Health Plan makes reasonable and clinically appropriate arrangements for the provision of such services by another provider, whichever occurs first.

19.8.3 In the event that the Health Plan fails to pay a non-contracting provider for any amounts owed by the Health Plan, Member may be responsible to the non-contracting provider for the cost of services.

19.9 Indemnification

Health Plan shall defend, hold harmless and indemnify the Group from any and all claims, liabilities, damages or judgments asserted against, imposed upon, or incurred by the Group that arise out of the Health Plan's negligence or intentional wrongdoing in the discharge of its responsibilities under this Agreement. The indemnification granted under this paragraph expressly includes indemnification with respect to expenses, legal fees, defense costs, court costs, or amounts paid in settlement or in satisfaction of any judgment or award.

SECTION 20
GRIEVANCE PROCEDURES

20.1 Applicability of the Grievance Procedures

All Member disputes and controversies arising under the Plan will be resolved pursuant to the Grievance Procedures set forth herein.

20.2 Grievances

Every Member has the right to communicate a grievance to Health Plan by calling the telephone number included in the Combined Evidence of Coverage and Disclosure Form, by submitting a written grievance to the address indicated below, by submitting a written grievance by facsimile or e-mail, or by completing an online grievance form.

Grievance Coordinator
ACN Group of California, Inc.
P.O. Box 880009, San Diego, CA 92168-009
1-800-428-6337
1 (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 e-mail, 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 Grievance Coordinator in collaboration with any other involved Health Plan departments. If the grievance pertains to a Quality of Care issue and is routine, Health Plan has up to three (3) business days to transfer the information to the Medical Director. If the grievance pertains to a Quality of Care issue and is urgent, Health Plan will promptly initiate the Expedited Review process.

Health Plan will provide a written statement on the disposition or pending status of any grievance except for grievances that are received by telephone, by facsimile, or by e-mail, 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 thirty (30) 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.

20.3 Expedited Review of Grievances

For a Member grievance 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 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 grievance.

20.4 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 (800) 428-6337; or write to ACN Group of California, Inc. at P.O. Box 880009, San Diego, CA 92168-009.

20.5 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.

20.6 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).

20.7 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 20.7, 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.

20.8 Department Review

The Combined Evidence of Coverage and Disclosure Form issued by Health Plan shall include the following statement advising Members of the Department's review of grievances:

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 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) 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 21
TERMINATION OF A MEMBER'S COVERAGE

21.1 Basis for Termination of a Member's Coverage

Health Plan may terminate a Member's coverage under this Agreement for any one or more of the following reasons:

21.1.1 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.

21.1.2 The Member fails to pay or make appropriate arrangements to pay a required Co-payment 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.

21.1.3 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.

21.1.4 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.

21.1.5 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.

21.1.6 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

21.1.7 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.

21.2 Reinstatement of Member

Subject to Section 21.4, 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 this Agreement for non-payment.

21.3 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.

21.4 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 or a Subscriber's health status or requirements for Chiropractic Services or Acupuncture Services may request a review of such 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 so notify Health Plan. Health Plan shall, within fifteen (15) days after receipt of such notice, either request a hearing or reinstate the Member. If after the hearing the Director determines that the termination or non-renewal is contrary to applicable law, Health Plan shall reinstate the Member retroactive to the time of the termination or non-renewal and shall be liable for the expenses incurred by the Member after such termination or non-renewal for Chiropractic Services or Acupuncture Services that would otherwise have received authorization as Covered Services.

21.5 Rescission

Member coverage is subject to rescission in the event that a Member fraudulently or intentionally provides incomplete or incorrect material information to Health Plan, or fraudulently or intentionally fails to 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. Further notice of the grounds of rescission are provided in Section 17.3 of the Combined Evidence of Coverage and Disclosure Form.

SECTION 22
TERMINATION OF THIS AGREEMENT

22.1 Termination at Will

This Agreement may be terminated for any reason by the Group upon giving thirty-one (31) days written notice to Health Plan prior to the end of the Initial Term or any Subsequent Term. This Agreement may be terminated for any reason by the Health Plan upon giving one hundred eighty (180) days written notice to Group prior to the end of the Initial Term or any Subsequent Term. In such event, benefits hereunder shall terminate for all Members as of the effective date of termination.

22.2 Termination for Cause by Health Plan

Health Plan may terminate this Agreement for any one or more of the following reasons:

22.2.1 Failure by the Group to pay the Total Monthly Premium as set forth in Section 5.1 if the Group has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

Receipt by the Health Plan of the proper Total Monthly Premium specified in Section 5.1 after cancellation of the Agreement for nonpayment shall reinstate the Agreement as though it had never been canceled if such payment is received on or before the succeeding monthly Premium Due Date. Provided, however, the Agreement shall not be reinstated if any of the following condition are met:

(A) In the notice of cancellation, Health Plan notifies Group that if payment is not received within fifteen (15) days a new application is required;

(B) If such payment is received more than fifteen (15) days after issuance of the notice of cancellation, Health Plan refunds such payment within twenty (20) business days; or

(C) If such payment is received more than fifteen (15) days after issuance of the notice of cancellation, Health Plan issues to Group, within twenty (20) business days of receipt of payment, a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

22.2.2 Fraud or deception by the Group in the use of services or facilities of the Health Plan or knowingly permitting such fraud or deception by another.

22.3 Notice of Termination of This Agreement

The Group shall promptly mail to each Member a legible, true copy of any notice of termination of this Agreement received by the Group from Health Plan, and shall promptly provide Health Plan with proof of such mailing including, but not limited to, the date thereof.

22.4 Return of Premiums for Unexpired Period

In the event of termination of this Agreement, 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.

22.5 Continuation of Coverage under Federal Law (COBRA)

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 Member's Group is subject to the provisions of COBRA. If Member's 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 Health Plan 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: Notifying Member in a timely manner of the right to elect continuation coverage; and notifying Health Plan in a timely manner of Member's election of continuation coverage.

22.5.1 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 or Domestic Partner.

22.5.2 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; or

(C) Divorce or legal separation of the Subscriber; or

(D) Loss of eligibility by a Family Dependent who is a child; or

(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.

22.5.3 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.

22.5.4 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 Policy 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 ends.

(H) The date coverage would otherwise terminate under this document.

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.

22.6 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.

22.6.1 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.

SECTION 23
GENERAL PROVISIONS

23.1 Compliance with Applicable Law

Health Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations, as well as any successor provisions to any of the foregoing provisions. Any term or condition required by such provisions to be included in the Agreement shall be incorporated into this Agreement by this reference, whether or not specifically provided in this Agreement.

23.2 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 shall 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.

23.3 Members Bound by This Agreement

By this 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 this Agreement. This Agreement shall be subject to amendment and termination in accordance with the terms of this Agreement without the necessity of either party obtaining the consent or concurrence of any Member. By electing such coverage or accepting its benefits, 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 this Agreement. In the case of conflicts between this Agreement and the Combined Evidence of Coverage and Disclosure Form, the provisions of the Combined Evidence of Coverage and Disclosure

Form shall be binding upon Health Plan notwithstanding any provisions of this Agreement that may be less favorable to Members.

23.4 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 covered children, or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law or provisions of this Agreement, Health Plan and the Group shall keep confidential, and shall take the usual precautions to prevent the unauthorized disclosure of any and all records required to be prepared or maintained in accordance with this Agreement.

23.5 Member Records

Health Plan and the Group shall maintain the confidentiality of any information relating to Members in accordance with any applicable statutes and regulations. No Member identifying information obtained as a result of providing services to Members under this Agreement shall be shared with third parties including Group, unless the Member consents to the disclosure of such information or as otherwise permitted under applicable law.

Members, who are adult patients, have the right to inspect their medical records and provide Health Plan, in writing, with corrections to any item or statement that the Member believes to be incomplete or incorrect in their medical records.

Corrections for each incomplete or incorrect item in the Member's record is limited to 250 words.

The Member must also clearly state in writing that the Member wishes his or her written corrections to be made part of his or her record.

Health Plan will attach the Member's corrections to the Member's records and include such corrections whenever Health Plan makes a disclosure of the incomplete or incorrect portion of a Member's records to any third party.

A STATEMENT DESCRIBING HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

To request a copy, call ACN Group of California, Inc. at (800) 428-6337.

23.6 Overpayments

Member shall agree to reimburse Health Plan, on demand, for 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 this Agreement; or

(C) Which exceeds the amounts to which the Member is entitled under this Agreement.

23.7 Clerical Error

Clerical error in connection with any record pertaining to coverage under this Agreement, whether such error is made by the Group or by Health Plan, shall neither invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

23.8 Amendments

This Agreement may be amended at any time by the mutual written consent of both parties. Any amendments to this Agreement shall be in writing and must be approved and executed by Health Plan. Health Plan specifically reserves the right to amend this Agreement upon thirty-one (31) days prior written notice to the Group. Such amendment shall be final and binding on the Group and on all Members covered under the Agreement unless the Group objects in writing to the amendment within thirty-one (31) days from receipt thereof. Health Plan may also amend this Agreement to comply with requirements of state and federal regulatory authorities, and shall give written notice to Group of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of the Group will not be required.

23.9 Waiver

The waiver by either party of any breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any other breach of this Agreement.

23.10 Severability

If any clause, sentence, provision, or other portion of this Agreement is, or becomes, illegal, null, void, or unenforceable for any reason, or is held by a court of competent jurisdiction to be so, the remainder of this Agreement shall remain in full force and effect.

23.11 Assignment

Neither Health Plan nor the Group may assign any of its rights and responsibilities under this Agreement to any person or entity without the prior written consent of the other party, which consent shall not be unreasonably withheld. The Group acknowledges that persons and entities under contract or affiliated with Health Plan may perform certain services under this Agreement. The Group acknowledges that, subject to applicable regulatory requirements, assignment by Health Plan of all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled

by or under common control with Health Plan shall not require the Group's prior written consent.

23.12 Successors and Assigns
This Agreement shall be binding upon the heirs, executors, administrators, or other legal representatives of the Group and is for the benefit of Health Plan, its successors and assigns.

23.13 Governing Law
The validity and interpretation of this Agreement and the rights and obligations of the parties under this Agreement shall be governed by the laws of the State of California.

23.14 Notice
All notices required by this Agreement shall be in writing and shall be sent by first-class mail or hand-delivered to the parties at their respective addresses set forth below. The date a notice is mailed or hand-delivered shall be considered the effective date of the notice.

To Health Plan:
ACN Group of California, Inc.
P.O. Box 880009, San Diego, CA 92168-009
Attn: Chief Executive Officer

To the Group:
Attn: Chief Executive Officer
A notice by Health Plan to a Member shall be mailed to the last address for the Member that was provided to Health Plan by the Group.

23.15 Entire Agreement
This Agreement, including the documents attached hereto and herein referenced contains the entire agreement between the parties with respect to the subject matter of this Agreement and supersedes all prior agreements and understandings, written or oral, between the parties with respect to the same subject matter.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the effective date referenced on the first page of this Agreement.

ACN Group of California, Inc.	**GROUP**
(the "Health Plan")	(the "Group")
By: _____	By: _____
Authorized Signature	*Authorized Signature*

Print Name: _____ Print Name: _____

Title: _____ Title: _____

Date: _____ Date: _____

ATTACHMENT A

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

ATTACHMENT B

SCHEDULE OF BENEFITS

SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP

UnitedHealthcare®

Acupuncture and Chiropractic Health Benefits Plan Offered by ACN Group of California, Inc.

Schedule of Benefits and Combined Evidence of Coverage and Disclosure Form

SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP

Chiropractic and Acupuncture Schedule of Benefits
Offered by ACN Group of California, Inc.

Benefit Plan:

$15 Copayment per Visit

40 Visit Annual Combined Maximum Benefit

Your Employer Group makes available to you and your eligible dependents programs that are included as part of your coverage for chiropractic and acupuncture. This program is provided through an arrangement with the ACN Group of California, Inc. d/b/a OptumHealth Physical Health of California (OptumHealth).

How to Use the Program

With this benefit, you have direct access to more than 3,000 credentialed chiropractors and over 950 credentialed acupuncturists servicing California. You are not required to pre-designate a participating provider or obtain a medical referral from your primary care physician prior to seeking chiropractic or acupuncture services. Additionally, you may change participating chiropractors or acupuncturists at any time.

If these services are covered services, you simply pay your copayment or coinsurance at each visit. There are no deductibles or claim forms to fill out. Your participating provider coordinates all services and billing directly with OptumHealth. Members are responsible for any charges resulting from non-covered services.

Annual Benefits

Benefits include chiropractic and acupuncture services that are medically necessary services rendered by a participating provider. In the case of acupuncture services, the services must be for a medically necessary diagnosis. Treatment is 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 and carpal tunnel syndrome.

In the case of chiropractic services, the services must be for a medically necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Maximum Benefit Limits

Each visit to a participating provider, as described below, requires a copayment by the member. A maximum number of visits per year to either a participating chiropractor and/or participating acupuncturist 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.

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 the maximum benefit. If an examination or re-examination is supplied without acupuncture treatment, 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 and acupuncturists. Members must use participating providers to receive their maximum benefit.

Types of Covered Services

Chiropractic Services:

1. An initial examination is performed by the participating chiropractor to determine the nature of the member's problem, and to determine medically necessary services to the extent consistent with professionally recognized standards of practice. At that time, a treatment plan of services will be provided. The initial examination will be provided to a member if the member seeks services from a participating chiropractor for any injury, illness, disease, functional disorder or condition. A copayment will be required for such examination.

2. Subsequent office visits, as set forth the 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.

3. Adjunctive therapy, as set forth the treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.

4. A re-examination may be performed by the 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.

5. X-rays and laboratory tests are a covered benefit in order to examine any aspect of the member's condition.

6. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by the participating chiropractor.

Acupuncture Services

1. An initial examination is performed by the participating acupuncturist to determine medically necessary services to the extent consistent with professionally recognized standards of practice. At that time, a treatment plan of services will be provided. The initial examination will be provided to a member if the member seeks services from a participating acupuncturist for any injury, illness, disease, functional disorder or condition. A copayment will be required for such examination.

2. Subsequent office visits, as set forth in the treatment plan, may involve acupuncture treatment, a brief re-examination and/or a combination of services. A copayment will be required for each office visit.

3. A re-examination may be performed by the 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 of California, Inc.
Attn.: Member Correspondence Unit
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 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 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, treatment for an educational requirement, and services relating to sexual transformation;
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 or acupuncture 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 the 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 separately by the member’s medical plan.

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.

ACN Group of California, Inc., dba OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009
619-641-7100
1-800-428-6337

TABLE OF CONTENTS

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
711 (TTY)
www.myuhc.com

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SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP

UnitedHealthcare®

Infertility Basic Diagnosis and Treatment Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form

This brochure contains important information for our Members about the UnitedHealthcare Infertility Basic Diagnosis and Treatment supplemental benefit. As a Member you shall be entitled to receive basic diagnostic services and treatment for infertility as described in this brochure. You will find important definitions in the back of this document regarding your infertility supplemental benefit.

Benefits

UnitedHealthcare's Basic Infertility Services must be Medically Necessary and consistent with accepted standards of care for the diagnosis and treatment of infertility. Services must be authorized and directed by the Participating Medical Group or the UnitedHealthcare SignatureValue® Advantage Participating Medical Group (for Advantage participants) and benefits are subject to the Exclusions and Limitations stated below:

Diagnosis of Infertility

a. Complete medical history.

b. General medical examinations. Examples include but are not limited to:
   - Pelvic exam;
   - Routine laboratory investigation for hormonal disturbances (e.g., FSH, LH, prolactin);
   - Cultures for infectious agents;
   - Serum progesterone determination;
   - Laparoscopy;
   - Hysterosalpingogram.
   - Semen analysis up to three times following five days of abstinence;
   - Huhner's Test or Post-Coital Examinations;
   - Laboratory studies (e.g., FSH, LH, prolactin, serum testosterone);
   - Testicular biopsy when Member has demonstrated azoospermia;
   - Scrotal ultrasound, when appropriate for azoospermia;
   - Electrical Assistance for Recovery of Sperm (EARS), when medically indicated, as when the Member is a paraplegic or quadriplegic, as approved by UnitedHealthcare's Medical Director or designee;
   - HIV, Hepatitis B surface antibody, Hepatitis C antibody, HTLV-1 and syphilis testing of partner prior to artificial insemination.

Treatment of Infertility

Coverage

All benefits, including physician services, procedures, diagnostic services are covered at 50 percent of cost Copayment (based upon UnitedHealthcare's contractual rate for the services provided with the infertility provider(s)).

Exclusions

- Artificial Insemination (AI)
- In-vitro Fertilization (IVF)
- Drug Services and Supplies
- Services not authorized and directed by the Participating Medical Group or the Advantage Participating Medical Group (for Advantage participants).
- Medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, anorgasmy or hyporgasmy.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any supplies, medications, services and/or procedures used for an excluded benefit, e.g., , ZIFT or IVF.
- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.

- Experimental and/or Investigational diagnostic studies or procedures, as determined by UnitedHealthcare's Medical Director or Designee.
- Advanced infertility procedures, as well as In Vitro Fertilization (IVF), and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, and ZIFT.
- Infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when infertility exists; e.g., use of another relative's sperm.
- Artificial insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
   a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
   b. 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;
2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the UnitedHealthcare Medical Director or designee determines that:
   a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
   b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
   c. The Member has received the lifetime benefit maximum of six artificial insemination procedures, cumulatively, under one or more UnitedHealthcare Health Plans, has occurred.
3. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes
4. Advanced Reproductive Therapy, as excluded under this Basic Infertility Services benefit are:
   a. In Vitro Fertilization (IVF). A highly sophisticated infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. If fertilization and cell division occur, the resulting embryo(s) are transferred to the uterine cavity where implantation and pregnancy may occur.
   b. Zygote Intrafallopian Transfer (ZIFT). An infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. The fertilized oocytes, or zygotes, are transferred to the fallopian tube before cell division occurs. The intent of this procedure is to have the zygote travel to the uterus via the fallopian tube.
5. Lifetime benefit maximum is individually cumulative for the Member over one or more UnitedHealthcare plans. Any Member that terminates from a UnitedHealthcare Health Plan with a lifetime benefit maximum, and subsequently re-enrolls in another UnitedHealthcare Plan with a lifetime benefit maximum, will carry over any previous benefit utilization calculated by his or her previous UnitedHealthcare benefit coverage into the new UnitedHealthcare Benefit plan. In the event the Member has exhausted the lifetime benefit maximum on the previous UnitedHealthcare Health Plan, the Member is no longer eligible for any further benefits.

UnitedHealthcare

Mental Health and Substance-Related and Addictive Disorder Services, Provided by U.S. Behavioral Health Plan, California

Schedule of Benefits

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 U.S Behavioral Health Plan, California (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, except in the event of an Emergency. USBHPC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient and Residential Treatment Medically Necessary Mental Health services provided at an Inpatient Treatment Center	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment (includes individual/ group counseling/ monitoring drug therapy) Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing , applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Substance-Related and Addictive Disorder Services

Inpatient and Residential Treatment Medically Necessary treatment of Substance-Related and Addictive Disorders, Including Medical Detoxification, provided at a Participating Facility	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]

Substance-Related and Addictive Disorder Services (Continued)

Outpatient Treatment Outpatient Treatment for Substance-Related and Addictive Disorder Services includes outpatient evaluation and treatment for chemical dependency: • individual and group Substance-Related and Addictive Disorder counseling; • medical detoxification • methadone maintenance treatment; and • outpatient treatment extended beyond 45 minutes.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child[3]

Inpatient and Residential Treatment Unlimited days	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing, applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

[1] Each Hospital Admission may require an additional Copayment. Please refer to your UnitedHealthcare of California Medical Plan *Schedule of Benefits.*

[2] Emergency and Urgently Needed Services are Medically Necessary behavioral health services required outside the Service Area to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient servility, including severe pain, and may result in 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, therefore such treatment cannot be delayed until the Member returns to the Service Area. Please refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for detailed information on this benefit.

[3] Severe Mental Illness (SMI) diagnoses include: Anorexia Nervosa; Bipolar Disorder; Bulimia Nervosa; Major Depressive Disorders; Obsessive-Compulsive Disorder; Panic Disorder; Pervasive Developmental Disorder, 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. Serious Emotional Disturbance (SED) of a Child Under Age 18 includes 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.

CALIFORNIA

Mental Health Services
Provided by U.S. Behavioral Health Plan, California

Supplement to the Combined Evidence of Coverage and Disclosure Form
Plan Large Group

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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 coverage of Mental Disorders. Whether your medical plan covers Substance-Related and Addictive Disorder coverage through U.S. Behavioral Health Plan, California (USBHPC) is dependent on if these services are purchased by the your Employer Group as a supplemental benefit.

This coverage includes the treatment of Severe Mental Illness (SMI) for adults and children and treatment for children 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 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 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. Coverage for Substance-Related and Addictive Disorder Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. Please refer to the Schedule of *Benefits* for coverage, if any.

What is a Mental Disorder?

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) 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 most recent edition of the DSM is covered. USBHPC does not cover services for conditions that the most recent edition of the DSM 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) includes the diagnosis and treatment of the following conditions:

- 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 one of the following: psychotic feature, risk of suicide or risk 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. 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 behavior intervention programs[, Medical Detoxification], Methadone Maintenance Treatment and Psychological Testing when necessary to diagnose 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 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 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. 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, and 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 behavior 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, and 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 for Members

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 that 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 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 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. 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, and 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, Methadone Maintenance Treatment [,Medical Detoxification] 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 most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. USBHPC does not cover services for conditions that the most recent edition of the DSM 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 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 PDD or autism:

A. **Inpatient**

1. **Inpatient Mental Health Services -** psychiatric inpatient services including room and board, drugs and services, including psychiatric inpatient services from licensed health providers including but not limited to psychiatrists and psychologists, provided at an Inpatient Treatment Center or 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 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

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 while the Member is confined to an Inpatient Treatment Center or 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 preauthorized 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 5. Your Medical Benefits,** of *the Combined Evidence of Coverage and Disclosure Form* or in an attached supplement, all services and benefits described below are excluded from coverage under this Behavioral Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*.

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 interventions 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 are provided by 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 or acupuncture.
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. Neurological services and tests, including, but not limited to, EEGs, PET scans, beam scans, MRIs, skull X-rays and lumbar punctures.
23. 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.
24. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations or career counseling.
25. 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.

26. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.

27. 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:

    (i) 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.

    (ii) It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.

    (iii) 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.

    (iv) 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.

    (v) 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).

    (vi) 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.

    (vii) The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.

    (viii) 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.)

    (ix) The sources 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."

28. Services provided to the Member on an Out-of-Network basis other than if authorized by the Plan.
29. Services rendered by a Non-Participating Provider are not covered, except for Emergency Services or services authorized by USBHPC.
30. Services rendered outside the Service Area are not covered, except for Emergency Services or Urgently Needed Services.
31. 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, 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*. 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:

   (x) "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.

   (xi) "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-Contracting 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-Contracting 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-Contracting 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-Contracting 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?

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 Severe Mental Illness and/or the Serious Emotional Disturbance of a Child 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, 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 a Member 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 or 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 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 that assist an individual 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-administered. .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 Disorders 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). An intervention if, and 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 condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM)* that results in clinically significant distress or impairment of mental, emotional or behavioral functioning. Mental Disorders 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).

Mental Health Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders, including but not limited to Severe Mental Illness and Serious Emotional Disturbance of a Child. Substance-Related and Addictive Disorder Services are only available if purchased by the Subscriber's Employer Group as a supplemental benefit.

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 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, (freestanding or hospital. based), 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;
  - (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;
- The child displays one of the following: psychotic features, risk of suicide or risk of 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). Severe Mental Illness includes the diagnosis and treatment of the following conditions:

- 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.

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.

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Pharmacy Schedule of Benefits

Summary of Benefits	Generic (Tier 1)	Brand Formulary (Tier 2)	Non-Formulary (Tier 3)
Retail Pharmacy Co-payment (per Prescription Unit or up to 30 days) A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives.	**$10**	**$25**	**$40**
Mail Service Pharmacy Co-payment (three Prescription Units or up to a 90 day supply) A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives.	**$10**	**$50**	**$80**

This Schedule of Benefits provides specific details about your prescription drug 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 coverage.

What do I pay when I fill a prescription?

For Prescription Drug Products at a retail pharmacy, you will pay the applicable Co-payment for a Prescription Unit or its retail cost, whichever is less. For Prescription Drug Products from Mail Order, you are responsible for paying the lower of either the applicable Co-payment or the prescription drug cost for that Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Participating 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 twice per 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 but no more frequent than quarterly.

When tier status changes occur, you may pay more or less for a prescription drug depending on the tier placement. You may access Formulary, Non-Formulary, tier placement and Co-payments by calling 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.

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.

Prior authorization

Select Tier 1, Tier 2 and Tier 3 drugs and Non-Formulary drugs require a Member to go through a Prior authorization process using criteria based upon U.S. Food and Drug (FDA) approved indications or medical findings, and the current availability of the medication. UnitedHealthcare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard

professional practice and are not otherwise excluded from coverage.

Because UnitedHealthcare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives have been tried. UnitedHealthcare understands that 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 Participating Physicians will need to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary.

For a list of the selected medications 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**.

Medication Covered by Your Benefit

When prescribed by your Participating Physician as Medically Necessary and filled at a Participating 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, or is on UnitedHealthcare's Selected Brands List. Prior authorization is necessary even if your Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's website at **www.myuhc.com**. If you choose to use a medication not included on the Formulary and not Prior authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication. You will not pay a rate higher than UnitedHealthcare's contracted rate for the brand-name drug. If the brand-name drug with the generic equivalent is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your brand-name Co-pay.
- **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, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to EpiPen®, Ana-Kits®, and Ana-Guard®). 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 Five under "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 an 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. 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 combined 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 medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered drugs**: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff is 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 Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" 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 Five 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, whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form.
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Drugs prescribed solely to treat hair loss.**
- **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. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical®, or Meridia®. This exclusion does not exclude coverage for drugs when Prior authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer's dementia.
- **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 Five of your medical Combined Evidence of Coverage and Disclosure Form entitled "Your Medical Benefits" for additional information.
- **Injectable medications**: Except as described under the section "Medications Covered By Your Benefit", injectable medications including, but not limited to, self-injectables, infusion therapy, allergy serum, 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 Five of your medical Combined Evidence of Coverage and Disclosure Form under "Your Medical Benefits".
- **Inpatient medications**: 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 Five 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 Participating 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 Participating Physician at a Participating 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 Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.
- **Medications dispensed by a Non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by Non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.

- **New medications that have not been reviewed for safety, efficacy and cost effectiveness and approved** by UnitedHealthcare are not covered unless Prior authorized by UnitedHealthcare as Medically Necessary.
- **Non-covered medical condition**: Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications 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 participating 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 Formulary, 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 Medical Review System as defined in the medical Combined Evidence of Coverage and Disclosure Form.
- **Over-the-Counter Drugs:** There is an exclusion of Over the Counter Drugs whether prescribed or not unless they are on UnitedHealth care's formulary or unless they are FDA-approved tobacco cessation drugs and products, or FDA-approved contraceptives, drugs, devises or other products both of which are provided as preventive benefit at $0 cost sharing subject to certain exception. For more information regarding coverage of certain over the counter drugs on the formulary, please see your Outpatient Prescription Drug Supplement and your Combined Evidence of Coverage under Family Planning and Tobacco Screenings. You may also contact UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**. Additionally, FDA-approved over-the-counter smoking cessation drugs prescribed by your Physician and female contraceptive methods are covered as preventive. For information regarding coverage of certain over the counter drugs including those on the formulary 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 that are comprised of identical active ingredients and dosage that are available over-the-counter are not covered except when Medically Necessary. 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.
- **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 lost, stolen, or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when 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 Five for additional information.
- **Sexual dysfunction medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to erectile dysfunction, impotence, anorgasmy or hyporgasmy, are not covered. An example of such medications includes Viagra®.
- **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. For information on UnitedHealthcare's smoking cessation program, refer to the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits, in the section entitled

"Outpatient Benefits", under "Health Education Services" 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) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. 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 Five, entitled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections entitled "Diabetic Self Management", "Durable Medical Equipment", or "Home Health Care and Prosthetics and Corrective Appliances".
- **Worker's Compensation**: Medication 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 Six under "Payment Responsibility".

UnitedHealthcare reserves the right to expand the Prior authorization requirement for any drug product.

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

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

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

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

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

Prescription Drug Products are added or deleted from the PDL only after careful review by a committee of practicing Physicians and pharmacists. This committee, called a National Pharmacy and Therapeutics (P&T) Committee, meets quarterly, and has the responsibility of reviewing new and existing drugs. This committee decides which drugs provide quality treatment at the best value. Updates to the Formulary/PDL occur quarterly. You may obtain a copy of the Formulary/ PDL by contacting Customer Service or from UnitedHealthcare's website at **www.myuhc.com.**

Our Prescription Drug List (PDL) Management Committee meets quarterly and is authorized to make Tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain Tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product. Whether a particular Prescription Drug Product is appropriate for a Member is a determination that is made by the Member and the prescribing Physician.

NOTE: The Tier status of a Prescription Drug Product may change periodically 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 access www.myuhc.com through the Internet or call the telephone number on your ID card for the most up-to-date Tier status

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 National Pharmacy and Therapeutics Committee meets regularly, on a quarterly basis, to review the PDL and add or remove Prescription Drug Products. The PDL Management Committee meets quarterly to determine tier placement. 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 twice per calendar year or Contract 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 Benefits Plan 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, but no more than quarterly.

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 the 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.

Emergency after hours

UnitedHealthcare will cover an emergency after hours prescription without Prior Authorization in the following situations:

- The prescription is for medication in conjunction with a hospital discharge, emergency room, or urgent care facility visit limited to a (7) seven day supply except for antibiotics which may be dispensed in up to a (15) fifteen day supply.
- Prescription Drug Products used for acute treatment and immediate use is required.
- All other after-hours requests go through the standard Prior Authorization process.
- Any time the prescribing Physician states that failure to supply the medication will result in a severe medical event or hospital admission.

Note: After hours Prior Authorization will not be approved for any of the following situations:

- Continuation of a restricted medication based solely on a previous authorization or previous use.
- A change to an existing Prior Authorization to extend the days' supply.
- A change to an existing Prior Authorization to correct erroneous information.
- Early refills of Maintenance Medications.
- Early refills for signature changes or dosage changes.

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 up to a 90 day supply of a drug unless a prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education not provided by a retail pharmacy. After the first and second fill at a retail pharmacy, the Plan may send a notice to a Member reminding them that there is a mail order program available by which in most cases s/he may obtain a 90 day prescription of a medication and if s/he prefers the program, s/he may call the telephone number on your ID card or going to UnitedHealthcare's web site at **www.myuhc.com**.. 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).

Note: Prescription Drug Products such as Schedule II substances (e.g., Morphine, Ritalin and Dexedrine), antibiotics, drugs used for short-term or acute illnesses, and drugs that require special packaging (including refrigeration), are not available through our Mail Order Pharmacy Program. Prescription medications prescribed for the treatment of sexual dysfunction are not available through the Mail Order Pharmacy Program.

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, including those drugs that you purchase prior to meeting the Annual Drug Deductible. 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 Supplement. We are not required to pass on to you, and do not pass on to you, such amounts.

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.

Definitions

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.

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.

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.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our review and change from time to time.

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.

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.

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, product or device 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 drug approved by the U.S. Food and Drug Administration for routine patient care during certain clinical trials for treatment of cancer or another life-threatening disease or condition. This does not include the drugs that are specifically part of the clinical trial.

A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Subscriber Agreement, this definition includes:

- glucagons, insulin, insulin syringes, blood glucose test strips,, lancets, inhaler extender devices, urine test strips 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 Five under “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 an 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. 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.

  See medical combined Evidence of Coverage and Disclosure Form for coverage of other injectable medication and equipment and supplies for the treatment of diabetes and pediatric asthma.

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 high cost and have restricted distribution by the United States Food and Drug Administration or require special handling, provider coordination, monitoring or patient education. You may access a complete list of Specialty Prescription Drug Products through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card. Specialty Prescription Drug Products include but are not limited to injectables, oral or inhaled medications, and are covered under all Tiers of the PDL.

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

Therapeutically Equivalent - when Prescription Drug Products have essentially the same clinical effect, safety profile, and contain the same or similar active ingredient

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

PCA838276-000

Effective 7/1/20

Real Appeal Rider

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Members through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

Benefits are provided for Real Appeal, which provides a virtual lifestyle intervention for weight-related conditions to eligible Members. The goal is to help those at risk from obesity-related diseases. Real Appeal is designed to support Members 18 years of age or older.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory online session.

These services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like additional information regarding these services, you may contact us through www.realappeal.com, https://member.realappeal.com or Customer Care at the number shown on your ID card.

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