UnitedHealthcare Select Plus

UnitedHealthcare Benefits Plan of California

Certificate of Coverage

For

the Plan CI8H

of

Veros Software Inc.

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UnitedHealthcare Select Plus

UnitedHealthcare Benefits Plan of California

Schedule of Benefits

IMPORTANT NOTICE - LIMITATIONS ON PROVIDER NETWORK AVAILABILITY

Benefits are restricted to Covered Health Care Services provided by Network providers for the following: Acupuncture Services; Cellular and Gene Therapy; Durable Medical Equipment (DME); Habilitative Services and Manipulative Treatment; Lab, X-Ray and Diagnostics - Outpatient; Obesity - Weight Loss Surgery; Ostomy Supplies; Preventive Care Services; Rehabilitation Services - Outpatient Therapy and Manipulative Treatment; Transplantation Services; Urinary Catheters; Virtual Care Services; Vision Exams This limitation does not apply to Emergency Health Care Services.

Enrolled Dependents who do not reside with the Subscriber and live outside the Service Area must see a Network Provider in order to obtain benefits for the Covered Health Care Services mentioned above.

Benefits are available from both Network providers and out-of-Network providers except as listed above. Covered Health Care Services are payable by us at a higher Benefit level from Network providers, and Covered Health Care Services obtained from out-of-Network providers are payable by us at a lower Benefit level.

DIRECTORY OF NETWORK PROVIDERS

The current directory of Network providers is available online at www.myuhc.com. You may obtain a paper copy of the network provider directory at no cost by calling the telephone number shown on your ID card.

AVAILABILITY OF TELEPHONE TRIAGE OR SCREENING SERVICES

Triage or screening services are the assessment of a Covered Person's health concerns and symptoms though communication, with a Physician, registered nurse or other qualified health professional acting within his or her scope of practice who is trained to screen or triage a Covered Person who may need care for the purpose of determining the urgency of the Covered Person's need for medical services. To access triage or screening services you should contact Customer Care during normal business hours at the telephone number on your ID card.

In addition, you can 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.

Although triage or screening services are available 24 hours per day, 7 days per week, it is not intended to replace or interfere with normal Physician/patient communication.

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

If you have a complaint regarding your ability to access Covered Health Care Services from a Network provider in a timely manner, call the telephone number shown on your ID card. If you would rather send your complaint to us in writing, the Customer Care representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the Department of Managed Health Care (DMHC) Help Center at the toll-free telephone number (1-888-466-2219) to receive assistance with this process, or submit an inquiry in writing to the DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725 or through the website: http://www.dmhc.ca.gov. The hearing- and speech- impaired may use the California Relay Service's toll-free telephone number 1-800-735-2929 or 1-888-877-5378 (TTY).

ACCESS TO A NETWORK PROVIDER

If medically appropriate care from a qualified provider cannot be provided within the Network, we will arrange 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.

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You may select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber, in order to obtain Network Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a PCP. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. However, you are not required to obtain Primary Care Physician visits from your selected or assigned Network Primary care Physician. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber, for that child. You may designate a Network Primary Care Physician by calling the telephone number shown your ID card or by visiting www.myuhc.com.

You may select any Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber and is accepting new patients. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. You may designate a Network Physician who specializes in obstetrics or gynecology. For obstetrical or gynecological care, you do not need a referral from a Network Primary Care Physician and may seek care directly from any Network Physician who specializes in obstetrics or gynecology. You do not need a referral prior to receiving Covered Health Care Services for reproductive and sexual health care.

You can get a list of Network Primary Care Physicians, Network obstetricians and gynecologists and other Network providers through www.myuhc.com or the telephone number on your ID card.

You may change your Network Primary Care Physician through the telephone number shown on your ID card or www.myuhc.com. Changes are permitted once per month. Changes submitted on or before the 15th of the month will be effective on the first day of the following month. Changes submitted on or after the 16th of the month will be effective on the first day of the second following month.

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network Provider.

Emergency Health Care Services Provided by an Out-of-Network Provider - Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under Allowed Amounts as described in this *Schedule of Benefits*. **For Emergency Health Care Services in an emergency department of a Hospital, prior authorization is not required, regardless of whether the provider is**

a Network Provider under the plan, and subject to the same cost sharing required if the services were provided by Network Provider. You will not pay more than the Network cost sharing amount.

Covered Health Care Services that are NOT Emergency Health Care Services Provided by an Out-of-Network Provider that is not chosen by you - Covered Health Care Services that are provided at a Network facility by an out-of-Network facility based Physician, or as a result of receiving services in a contracting facility, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts in this *Schedule of Benefits*. **You will not pay more than the Network cost sharing amount. The Network cost sharing amount means the same cost sharing that you would pay for the same Covered Health Care Services if they were received from a contracting individual health professional. Additionally, the Network deductible and out-of-pocket limit apply for Covered Health Care Services rendered by an out-of-Network provider in a Network contracting health facility, or as a result of receiving services in a contracting facility, including a hospital, ambulatory surgery or other outpatient setting, laboratory and radiology or imagining center. When you receive Covered Health Care Services from a Network facility and as a result of which, you receive additional Covered Health Care Services from an out-of-Network individual health professional, you will not pay more than the Network cost sharing amount.**

Covered Health Care Services Provided by an Out-of-Network Provider that are NOT Emergency Health Care Services from an out-of-Network facility based Physician that you have chosen - Covered Health Care Services that are provided at a Network facility by an out-of-Network facility based Physician, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described in this *Schedule of Benefits*. **As a result, you may be responsible for the difference between the amount billed by the out-of-Network facility based Physician and the reimbursement amount that is an Allowed Amount. The payments you make to out-of-Network facility based Physicians for charges above the Allowed Amounts do not apply towards any applicable Out-of-Pocket Limit.**

An out-of-Network facility based Physician may bill or collect the out-of-network cost sharing from you, if applicable, only when you consent in writing and that written consent demonstrates satisfaction of all the following criteria:

- At least 24 hours in advance of care, you consent in writing to receive Covered Health Care Services from the identified out-of-Network facility based Physician.
- The consent must be obtained by the out-of-Network facility based Physician in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent cannot be obtained by the facility or any representative of the facility. The consent cannot be obtained at the time of admission or at any time when you are being prepared for surgery or any other procedure.
- At the time consent is provided, the out-of-Network facility based Physician must give you a written estimate of your total out-of-pocket cost of care. The written estimate must be based on the out-of-Network based Physician's billed charges for the Covered Health Service to be provided. The Out-of-Network facility based Physician cannot attempt to collect more than the estimated amount without receiving separate written consent from you or your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the out-of-Network facility based Physician to change the estimate.
- The consent must advise you that you may elect to seek care from a Network provider or may contact us in order to arrange to receive the Covered Health Care Service from a Network provider for lower out-of-pocket costs.
- The consent and estimate must be provided to you in the language spoken by you, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the California Health and Safety Code.

The consent must advise you that any costs incurred as a result of your use of the out-of-Network Benefit must be in addition to the Network cost-sharing amounts and may not count toward the annual Out-of-Pocket Limit on Network Benefits or a deductible, if any, for Network benefits.

If you disagree with an Allowed Amounts determination, you can request an appeal. The complaint and appeals process is described under Section 6: Questions, Complaints and Appeals in the Evidence of Coverage. You may also call us at the telephone number on your ID card.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

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

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

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

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category. You are not required to obtain prior authorization to obtain direct access to Covered Health Care Services for reproductive and sexual health care services.

You do not need a referral to obtain Covered Health Care Services for women's reproductive and sexual health care services. Reproductive and sexual healthcare services include the following:

- Prevention or treatment of pregnancy.
- Prevention, diagnosis and treatment of an infectious, communicable or sexually transmitted disease, including HIV.
- Abortion.
- Treatment of rape or sexual assault, including medical care related to the diagnosis or treatment of the conditions and collection of medical evidence.

Prior authorization is not required for emergent or urgent services.

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

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings.

Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Care Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

- Ambulance - non-emergent air and ground.
- Cellular and Gene Therapy.
- Clinical trials.
- Congenital heart disease surgery.
- Diabetes equipment - insulin pumps over $1,000
- Fertility Preservation for Iatrogenic Infertility
- Habilitative Services.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or exceeding 96 hours for a cesarean section delivery. Initial maternity stays up to 48 hours for vaginal delivery and up to 96 hours for a cesarean delivery are exempt from prior authorization. Prior authorization is not required for Emergency admissions.
- Major Diagnostic and Imaging - Outpatient
- Mastectomy Services
- Mental Health Care and Substance Related and Addictive Disorders Services - inpatient services (including services at a Residential Treatment facility). Prior authorization only applies to non-Emergency inpatient admissions. Prior authorization needed before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.
- Preimplantation Genetic Testing (PGT) and Related Services
- Prosthetic devices over $1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic cardiac catheterization and cardiac electrophysiology implant and sleep apnea surgeries.
- Temporomandibular joint services.
- Therapeutics - only for the following services: intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplantation Services.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care

Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid. If you have a question regarding a determination of whether a service is Medically Necessary, call the telephone number on your ID card. If you disagree with a determination of whether a service is Medically Necessary, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the Evidence of Coverage. You may also call *Customer Care* at the telephone number on your ID card.

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Schedule of Benefits*. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a	***Network*** $1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family. An individual's payment toward the Annual Deductible is limited to the $1,000 per Covered Person Annual Deductible amount stated above. ***Out-of-Network*** $3,000 per Covered Person, not to exceed $6,000 for all Covered

Payment Term And Description	Amounts
group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	Persons in a family. An individual's payment toward the Annual Deductible is limited to the $3,000 per Covered Person Annual Deductible amount stated above.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Supplement*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts.	***Network*** $5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family. An individual's payment toward the Out-of-Pocket Limit is limited to the $5,000 per Covered Person Out-of-Pocket Limit amount stated above. After an individual meets this Out-of-Pocket Limit amount, the Covered Person is no longer responsible for cost sharing for the rest of the year. Allowed amounts for out-of-Network Emergency Health Care Services accrue to the Out-of-Pocket Limit. Emergency Health Care Services include expenses for the emergency facility, professional services and emergency medical transportation. The Out-of-Pocket Limit includes the Annual Deductible. ***Out-of-Network*** $15,000 per Covered Person, not to exceed $30,000 for all Covered Persons in a family. An individual's payment toward the Out-of-Pocket Limit is limited to the $15,000 per Covered Person Out-of-Pocket Limit amount stated above. After an individual meets this Out-of-Pocket Limit amount, the Covered Person is no longer responsible for cost sharing for the rest of the year. Allowed amounts for out-of-Network Emergency Health Care Services accrue to the Network Out-of-Pocket Limit. Emergency Health Care

Payment Term And Description	Amounts
	Services include expenses for the emergency facility, professional services and emergency medical transportation. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount. • Co-pay/ co-insurance or retail price Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Acupuncture Services			
20 treatments per year.	***Network*** $25 per visit ***Out-of-Network*** Out-of-Network Benefits are not available.	 Yes Out-of-Network Benefits are not available.	 No Out-of-Network Benefits are not available.
2. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as reasonably possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance Allowed Amounts for Emergency ambulance transport provided by an out-of-Network provider will be calculated as described below under Allowed Amounts in this Schedule of Benefits.	***Network*** *Ground Ambulance* 20% *Air Ambulance* 20% ***Out-of-Network*** Same as Network	 Yes Yes Same as Network	 Yes Yes Same as Network
Non-Emergency Ambulance Ground or air ambulance.	***Network*** *Ground Ambulance* 20% *Air Ambulance* 20%	 Yes Yes	 Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network *Ground Ambulance* 50% *Air Ambulance* 50%	 Yes Yes	 Yes Yes
3. Cellular and Gene Therapy			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider. Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this Schedule of Benefits may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits. ***Out-of-Network*** Out-of-Network Benefits are not available.		
4. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as you are accepted to participate in a clinical trial. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this Schedule of Benefits may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
5. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as you are notified that a surgery is scheduled. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per surgery			
Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
6. Dental Services and Oral Surgery- Accident Only			
	Network 20% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes Same as Network
7. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any diabetes equipment for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot	***Network*** Benefits for diabetes self-management and training/diabetic		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Care For Self-Management and Training, cost sharing will not exceed the costs for Physician office visit.	eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
8. Diabetes Treatment			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this Schedule of Benefits may apply. Other categories of Covered Health Care Services may also apply Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician. Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. See prescription drug benefit and Durable Medical Equipment (DME), Orthotics and Supplies for coverage of diabetes equipment and supplies. ***Out-of-Network*** Depending upon where the Covered Health Care Service is		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
9. Durable Medical Equipment (DME), Orthotics and Supplies			
To receive Network Benefits, you must purchase, rent, or obtain the DME or orthotic from the vendor we identify or purchase it directly from the prescribing Network Physician.	***Network*** 20% ***Out-of-Network*** Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.
10. Emergency Health Care Services - Outpatient			
Note: A qualified Physician would determine if you are stable for transfer to a Network Hospital and if such transfer is medically appropriate. Network Benefits will not be stopped until after you are stabilized and the care no longer constitutes Emergency Health Care Services as defined in the Agreement Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** 20% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes Same as Network
11. Enteral Nutrition			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
12. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per service.			
Limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under *Preimplantation Genetic Testing (PGT) and Related Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Agreement.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
13. Gender Dysphoria			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	each Covered Health Care Service category in this *Schedule of Benefits*.		
14. Habilitative Services and Manipulative Treatment			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per admission. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Manipulative Treatments are limited to 24 visits per year. Visit limits for Out-of-Network Benefits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment. Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	*Outpatient* $25 per visit for Manipulative Treatment services provided by a Network Specialist or other Network Physician	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	$25 per visit for all other habilitative services	Yes	No
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network For all therapies, except for physical therapy, occupational therapy, and Manipulative Treatments: 50% For physical therapy, occupational therapy, and Manipulative Treatments, Out-of-Network Benefits are not available.	Yes.	Yes.
15. Hearing Aids			
Limited to $2,500 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
16. Home Health Care			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per visit.			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For Out-of-Network Benefits, Allowed Amounts are limited to $150 per visit	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
17. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per Inpatient Stay in a hospice facility. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
18. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
	Network 20% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
19. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient	***Network*** 20% ***Out-of-Network*** Out-of-Network Benefits are not available.	 Yes Out-of-Network Benefits are not available.	 No Out-of-Network Benefits are not available.
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** 20% ***Out-of-Network*** 50%	 Yes Yes	 No Yes
20. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
$1,000 per scheduled or non-scheduled service.			
	Network 20% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
21. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. For Out-of-Network Benefits Outpatient services that require prior authorization: partial hospitalization/ day treatment; intensive outpatient treatment programs; outpatient electroconvulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; intensive behavioral therapy, including applied behavior analysis (ABA). If you do not obtain prior authorization as required, you will be responsible for paying all charges no Benefits will be paid.			
Outpatient Office Visits include: • Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group counseling, individual/group evaluations and treatment,	***Network*** *Inpatient* 20% *Outpatient* $25 per visit	 Yes Yes	 Yes No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
referral services, and medication management *All Other Outpatient Office Visits* include but not limited to: • 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.			
	20% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
	Out-of-Network		
	Inpatient		
	50%	Yes	Yes
	Outpatient		
	50%	Yes	Yes
	50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
22. Obesity - Weight Loss Surgery			
Prior Authorization Requirement **It is important that you notify us regarding your intention to have surgery. Your notification will**			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Out-of-Network Benefits are not available.		
23. Ostomy Supplies			
	Network 20% ***Out-of-Network*** Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.
24. Pharmaceutical Products - Outpatient			
Administered on an outpatient basis in a Hospital, Alternate Facility or Physician's office.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
25. Physician Fees for Surgical and Medical Services			
	Network 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
26. Physician's Office Services -			

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Sickness and Injury			
In addition to the office visit Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	***Network*** $25 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit	Yes	No
	Out-of-Network 50%	Yes	Yes
27. Pregnancy - Maternity Services			
Prior Authorization Requirement For outpatient maternity services, you may receive obstetrical and gynecological Covered Health Care Services directly from a Physician without a referral or seeking prior authorization. For Inpatient Stays for delivery, you may receive maternity service, including labor and delivery without			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
a referral or seeking prior authorization. For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per Inpatient Stay of more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hour for the mother and newborn child following a cesarean section delivery. **It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit. All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care Act will be provided without cost share. Please refer to Preventive Care Services below.	***Network*** Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of your pregnancy. ***Out-of-Network*** Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
28. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per service.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Benefit limits for related services will be the same as, and combined with, those stated under *Fertility Preservation for Iatrogenic Infertility*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Supplement*.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
29. Preventive Care Services			
Physician Office and other Preventive Services	***Network*** No charge	No	No
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
30. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits	***Network*** 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.	***Out-of-Network*** 50%	Yes	Yes
31. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per scheduled and/or non-scheduled procedures. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per scheduled and/or non-scheduled procedures.			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
32. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Manipulative Treatments are limited to 24 visits per year. • Visit limits are not applied to occupational therapy, physical therapy or speech therapy for	***Network*** *Any combination of Manipulative Treatment and physical therapy for*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	*new low back pain* None for the first 3 visits in a year; $25 per visit for all other visits in that year	Yes	No
	All other therapies $25 per visit for Manipulative Treatment and vision therapy services provided by a Network Specialist	Yes	No
	$25 per visit for all other rehabilitation services	Yes	No
	Out-of-Network For all therapies, except for physical therapy, occupational therapy, and Manipulative Treatments: 50% For physical therapy, occupational therapy, and Manipulative Treatments, Out-of-Network Benefits are not available.	Yes.	Yes.
33. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 20% ***Out-of-Network***	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	Yes
34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days or as soon as reasonably possible before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per admission. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
• 100 days per year in a Skilled Nursing Facility. • No day limits for Inpatient Rehabilitation Facility Services	***Network*** *Skilled Nursing Facility* 20% *Inpatient Rehabilitation Facility Services* 20% ***Out-of-Network*** 50%	 Yes Yes Yes	 Yes Yes Yes
35. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic cardiac catheterization and cardiac electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per scheduled and/or non-scheduled services.			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
For Out-of-Network Benefits, Allowed Amount for Facility Fees are limited to $760 per date of service	20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
36. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per Inpatient Stay. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions. If you do not obtain prior authorization as required, 38you will incur a penalty of $1,000 per Inpatient Stay.			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
37. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, you will incur a penalty of $1,000 per service.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network 20% ***Out-of-Network*** 50% For dialysis services, Out-of-Network Benefits are not available.	Yes Yes For dialysis services, Out-of-Network Benefits are not available.	Yes Yes For dialysis services, Out-of-Network Benefits are not available.
38. Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as you qualify for a transplant. If you don't obtain prior authorization and do not use a Designated Provider, Network Benefits will not be paid.			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Out-of-Network Benefits are not available.		
39. Urgent Care Center Services			
In addition to the Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*.	***Network*** $50 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	***Out-of-Network*** 50%	Yes	Yes
40. Urinary Catheters			
	Network 20%	Yes	Yes
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
41. Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	***Network*** None	Yes	No
	Out-of-Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
42. Vision Exams			
Limited to 1 exam every 2 years.	***Network*** $25 per visit ***Out-of-Network*** Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.
Other Benefits			
43. Dental Anesthesia Services			
Services are limited to Covered Persons who are one of the following: • A child under seven years of age. • A person who is developmentally disabled, regardless of age. • A person whose health is compromised and for whom general anesthesia is required, regardless of age.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
44. Mastectomy Services			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
45. Off-Label Drug Use and Experimental or Investigational Services			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
46. Osteoporosis Services			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
47. Telehealth Services			
Co-payments and any deductible for *Hospital - Inpatient Stay* as stated in this *Schedule of Benefits* may apply. Other categories of Covered Health Care Services may also apply.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		

Allowed Amounts

Benefits for Covered Health Care Services are based on Allowed Amounts. Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network provider (other than services otherwise arranged by us, or services received from a Network Physician or other provider at a Network facility), you will be responsible to the out-of-Network provider for any amount billed that is greater than the amount we determine to be an Allowed Amount as described below. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Agreement*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are calculated, based on:
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.

- Certain Covered Health Care Services apply an Allowed Amount as shown below.
  - Facility fees for services provided as described under *Surgery - Outpatient* in the Agreement: up to $760 per date of service.
  - Home health care services, for which Benefits are provided as described under *Home Health Care* in the Agreement: up to $150 per visit.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to calculate a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

  We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

  IMPORTANT NOTICE: Out-of-Network providers at a Network facility may not bill you for any difference between the provider's billed charges and the Allowed Amount described here.

For Covered Health Care Services received at a Network facility on a non-Emergency basis from an out-of-Network facility based Physician that is not chosen by you, or as result of receiving services in a contracting facility, the Allowed Amount is based on the greater of 125% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* or the average contracted rate for the same or similar service within the geographic market.

IMPORTANT NOTICE: Out-of-Network facility based Physicians at a Network facility that are not chosen by you, or as a result of receiving services in a contracting facility, may not bill you for any difference between the Physician's billed charges and the Allowed Amount described here.

Please refer to "Selecting a Network Primary Care Physician" provision under "How Do You Access benefits", at the beginning of this Schedule of benefits, for more information related to "Covered Health Care Services Provided by an Out-of-Network Provider that are NOT Emergency Health Services from an out-of-Network facility based Physician that you have chosen" for more information.

For Covered Health Care Services received at a Network facility on a non-Emergency basis from an out-of-Network facility based Physician that you have chosen, the Allowed Amount is based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market with the exception of the following:

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

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

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

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

IMPORTANT NOTICE: When you choose to use Out-of-Network facility based Physicians, they may bill you for any difference between the Physician's billed charges and the Allowed Amount described here.

For Emergency Health Care Services and Emergency ambulance transportation provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or determined based upon the higher of:

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

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

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

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

IMPORTANT NOTICE: When you choose to use Out-of-Network facility based Physicians, they may bill you for any difference between the Physician's billed charges and the Allowed Amount described here.

For Emergency Health Care Services and Emergency ambulance transportation provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or calculated based upon the greater of:

- The median amount negotiated with Network providers for the same service.
- The amount for the Emergency Health Care Service calculated using the same method used for Out-of-Network Benefits." Please see the provision titled **"For Out-of-Network Benefits, Allowed Amounts are based on either of the following"** under the Allowed Amounts section in the Schedule of Benefits for additional information.
- The amount that would be paid under Medicare for the Emergency Health Care Service, excluding any Network Co-payment or Co-insurance.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

IMPORTANT NOTICE: Out-of-Network providers at a Network facility may not bill you for any difference between the provider's billed charges and the Allowed Amount described here.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

Provider Network

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

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

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

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

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

Second Medical Opinion

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Physician or appropriately qualified health care professional. When a second opinion is requested by you or by a Network Physician or health professional that is treating you, we will authorize a

second opinion by an appropriately qualified health care professional. The Physician or appropriately qualified health care professional acting within his or her scope of practice must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion.

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 function, or substantial impairment (including, but not limited to, a 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 Physician 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 initial treating Physician and still have serious concerns about the diagnosis or treatment.

In most cases, you or your treating Physician or health care professional will request a second medical opinion without consulting us. However, in the event that we approve a request by you for a second medical opinion, you shall be responsible only for the costs of applicable co-payments that are required for similar referrals.

The second medical opinion will be documented in a consultation report, which will be made available to you and your treating Physician or health care professional. It will include any recommended procedures or tests that the Physician or health care professional giving the second opinion believes are appropriate.

Please Note: The fact that an appropriately qualified Physician or health care professional 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. If the recommended action is not medically necessary or is not a Covered Health Care Service, you will also remain responsible for paying any appropriate fees to the Physician or health care professional that performs that recommended action.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Primary Care Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Care Physician to coordinate care through an out-of-Network provider.

UnitedHealthcare Benefits Plan of California

Select Plus

Combined Evidence of Coverage and Disclosure Form

5701 Katella Avenue

Cypress, CA, 90630

1-800-260-2773

What Is the Combined Evidence of Coverage and Disclosure Form?

This *Combined Evidence of Coverage and Disclosure Form (Certificate)* is part of the Agreement that is a legal document between UnitedHealthcare Benefits Plan of California and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Agreement. We issue the Agreement based on the Group's *Application* and payment of the required Agreement Charges.

In addition to this *Certificate,* the Agreement includes:

- The *Schedule of Benefits*.
  - The Pharmacy Schedule of Benefits,
  - The Mental Health Care Services, Substance-Related and Addictive Disorder Services within the medical Schedule of Benefits
- The Group's *Application*.
- Riders including, as applicable:
  - Outpatient Prescription Drug Benefit
- EOC Supplement - Mental Health. Other Amendments/ Addendums, if applicable.

You can review the Agreement at the Group's office during regular business hours.

Can This Combined Evidence of Coverage and Disclosure Form Change?

We may, from time to time, change this *Certificate by* attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. If there are material changes in any of the terms of the Policy, UnitedHealthcare will provide sixty (60) days advance notice to the Group. The Group shall be responsible for delivering the notice to all Covered Persons and to other persons eligible for coverage.

Other Information You Should Have

We have the right to change, modify, withdraw or add Benefits, or to end the Agreement, as permitted by law.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Agreement will take effect on the date shown in the Agreement. Coverage under the Agreement starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Agreement will remain in effect as long as the Agreement Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Agreement in the State of California. The Agreement is subject to the laws of the State of California and ERISA unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, State of California law governs the Agreement.

We are subject to the requirements of the California Knox-Keene Health Care Service Plan Act of 1975, and the regulations promulgated thereunder (collectively the "Knox-Keene Act"), and any provision required to be in this Agreement by the Knox-Keene Act shall bind us whether or not provided in this Agreement.

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 Benefits Plan of California 1-800-260-2773 / TTY: 711. If you need more help, call DMHC Help Line at 1-888-466-2219.

Introduction to Your Combined Evidence of Coverage and Disclosure Form

This *Certificate* and the other Agreement documents describe your Benefits, as well as your rights and responsibilities, under the Agreement.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Benefits Plan of California. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.myuhc.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

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

Choice of Physicians and Providers

Please see your *Schedule of Benefits* for your Co-payment and Co-insurance.

Network Providers include Physicians, Specialists, other health care providers, Hospitals, and other facilities that contract with us to provide services to our Members.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Agreement. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Agreement issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Agreement. If you have questions about this, contact your Group.

Be Aware the Agreement Does Not Pay for All Health Care Services

The Agreement does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

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 Physician 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 is not available from a Network provider and cannot be arranged timely, your Network 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 ID card.

If you call the number at the back of your ID card, 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 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 Benefits Plan 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. If you need more help, call DMHC Help Line at 1-888-466-2219.

Important Language Information

You may be entitled to the right and services below. These rights apply only under California law. These rights do not apply to all languages.

You can get an interpreter to help you talk with your doctor or health plan. To get help in your language, please call your health plan at:

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

Language services are at no cost to the Member. Written information may be available in some languages. If you need more help, call DMHC Help Line at 1-888-466-2219.

Pay Your Share

You must meet any applicable Deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable Deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Annual Deductible

The Annual Deductible is the amount incurred for a Covered Health Care Service that you are responsible for paying before benefits are payable under the Agreement. The amounts applied towards the Annual Deductible are based upon UnitedHealthcare Benefits Plan of California's contracted rate. The Deductible is waived for certain covered 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 year. The Annual Deductible is in addition to any Co-payment responsibility. The Annual Deductible applies to the Out-of-Pocket Limit.

Out-of-Pocket 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 Out-of-Pocket 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 Out-of-Pocket Limit; these services are specified in the *Schedule of Benefits*.

Note: The Out-of-Pocket Limit applies to Covered Health Care Services under the Agreement as indicated in this *Schedule of Benefits,* including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider,* if applicable.

What If You Get a Bill?

If you are billed for a Covered Health Care Service provided or authorized by us or if you receive a bill for Emergency Health Care 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 Benefits Plan of California.
2. Give the provider your Health Plan information, including your name and UnitedHealthcare Benefits Plan of California Member number.
3. Forward the bill to:

   UnitedHealthcare Benefits Plan of California

   Claims Department

   P.O. BOX 30555

   Salt Lake City, UT 84130-0555

Include your name, your 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. If you need additional assistance, call the telephone number on your ID card.

Please Note: Your provider will bill you for services that are not covered by UnitedHealthcare Benefits Plan of California or haven't been properly authorized. You may also receive a bill if you have exceeded UnitedHealthcare Benefits Plan of California's coverage limit for a benefit.

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.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Agreement's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Agreement for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Agreement will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Combined Evidence of Coverage and Disclosure Form*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Agreement, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Agreement.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*. Out-of-Network Providers may not balance bill you for Emergency Health Care Services. For Emergency Health Care Services, you are only required to pay the Co-payment amount specified in your *Schedule of Benefits*.

For emergency medical transportation bills, UnitedHealthcare will pay for the reasonable and customary value as determined by UnitedHealthcare minus any member cost-share. You are responsible to pay the outstanding balance. Other than your cost share, any remaining balance does not apply to your out-of-pocket maximum.

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 pursuant 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.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Agreement is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Agreement.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Agreement.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or.
- Certified by a national accrediting body.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest available emergency Facility having the expertise to your condition in or out of the area. The use of an ambulance (land or air) is covered if you reasonably believe there is an Emergency

Medical Condition or psychiatric condition that requires ambulance transport to access Emergency Health Care Services. Such coverage includes ambulance transport services provided through 911 emergency response systems.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.
- When a Physician determines the Member's condition requires the use of a service that only a licensed ambulance or psychiatric transport van can provide if other means would endanger the Member's health.

For the purpose of this Benefit the following terms have the following meanings:

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

3. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

4. Clinical Trials

Routine patient care costs incurred while taking part in an approved clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the approved clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the approved clinical trial criteria stated below.

A Member is considered a Qualified Individual if the Member is eligible to take part in the approved clinical trial according to the trial’s protocol and either a Network treating Physician has concluded that the Member’s participation in the trial would be appropriate because the Member meets the trial protocol; or

the Member self-refers to the trial and has provided medical and scientific information to establish that participation in the trial is consistent with the trial protocol.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Benefits are available only when you are:

- Eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening disease or condition, or
- Either:
  - the referring health care professional is a participating health care provider and has concluded that your participation in such trial would be appropriate based upon you meeting the conditions that are eligible for the clinical trial, or
  - you provide medical and scientific information establishing that your participation in such trial would be appropriate based upon you meeting the conditions that are eligible for the clinical trial.

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

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

Routine costs for clinical trials do not include:

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

- Drugs, items, devices, and services provided by the research sponsors free of charge for any person taking part in the trial.

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

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying 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. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
    - *Centers for Disease Control and Prevention (CDC)*.
    - *Agency for Healthcare Research and Quality (AHRQ)*.
    - *Centers for Medicare and Medicaid Services (CMS)*.
    - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
    - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
    - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system 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 individuals 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.

With respect to a clinical trial for the treatment of cancer or other Life-Threatening disease or condition, Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers. If one or more Network providers are conducting an approved clinical trial, we may require that you participate in the clinical trial through a Network provider if the Network provider accepts you as a clinical trial participant. We may also restrict coverage to an approved clinical trial in the state of California, unless the clinical trial is not offered or available through a Network provider in the state of California.

5. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.

- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under Physician Fees for Surgical and Medical Services.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for CHD services.

6. Dental Services and Oral Surgery - Accident Only

Dental services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Agreement, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Agreement.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

7. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

8. Diabetes Treatment

Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Benefits for diabetes prescription items (limited to insulin, medication for the treatment of diabetes, insulin syringes, blood glucose test strips, lancets, urine test strips, ketone test strips and tablets and glucagon) are described in the *Outpatient Prescription Drug* Supplement.

For diabetes equipment, Benefits will be the same as those stated under Durable Medical Equipment (DME), Orthotics and Supplies.

9. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item is clinically appropriate to meet your functional needs, but one is less expensive, Benefits are available only for the less expensive item.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Combined Evidence of Coverage and Disclosure Form*.
- Enteral feeding pumps and supplies.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to a health condition. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations, under Medical Supplies and Equipment*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

10. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services to treat Emergency Medical Conditions must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize or eliminate the medical or psychiatric condition and/or treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

11. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

12. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.

- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under the *Outpatient Prescription Drug Supplement* or under *Pharmaceutical Products* in this section.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

13. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

14. Habilitative Services and Manipulative Treatment

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.

- Daycare.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

This exclusion does not apply to Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices.*

15. Hearing Aids

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). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this Combined Evidence of Coverage and Disclosure Form. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

16. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

17. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

18. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Nursing and other licensed health professionals, or other professionals as authorized under California law.

19. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography. Benefits are provided whether mammography testing is ordered or referred by a Physician, a nurse practitioner or a certified nurse midwife.
- All generally medically accepted cancer screening tests that are performed for diagnostic reasons. (Cancer screenings for preventive care are described under *Preventive Care Services*."

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

20. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Covered Health Care

Services under this section include all generally medically accepted cancer screening tests that are performed for diagnostic reasons. (Cancer screenings for preventive care are described under *Preventive Care Services.*)

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

21. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office in a group or individual therapy session. Inpatient hospitalizations cover room and board. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits under this section include the diagnosis and all Medically Necessary treatment of Severe Mental Illness (SMI) of a Member of any age and Serious Emotional Disturbances (SED) of an Enrolled Dependent child under the same terms and conditions that apply to medical conditions as required by California law. This includes, but is not limited to, Co-payments and any Deductibles.

Mental Health Care Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Emergency Health Care Services.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management, monitoring of drug therapy and other associated treatments.
- Psychiatric observation for an acute psychiatric crisis.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention
- Services at a Residential Treatment Facility.
- Behavioral Health Treatment for Pervasive Development Disorders ("PDD") or Autism under the same terms and conditions that apply to medical conditions. Medically Necessary Behavioral Health Treatment will not be denied or unreasonably delayed:
    - Based on an asserted need for cognitive or intelligence quotient (IQ) testing.
    - On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or

- On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

The scope of treatment services for mental health conditions that a plan must cover varies depending on whether the condition is defined as an SMI, SED or another type of mental disorder or substance use disorder that is not an SMI/SED. Notwithstanding any exclusions or limitations described in this EOC, all treatment services for an SMI or SED mental health condition shall be covered as medically necessary.

Covered Health Care Services provided for Severe Mental Illness of a Member of any age and Serious Emotional Disturbances of a Child must meet the definitions of Severe Mental Illness and Serious Emotional Disturbances of a Child as defined in *Section 9: Defined Terms*.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described under *Section 6: Questions, Complaints and Appeals*.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Combined Evidence of Coverage and Disclosure Form*. The following terms used in this section are defined as follows:

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.

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 Qualified Autism Service Provider or 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 Qualified Autism Service Provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training and experience, certified by a 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.

Qualified Autism Service Professional - an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- Is supervised by a 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 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.

Professional services and treatment programs are covered, 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 meet all of the following criteria:

- The treatment is prescribed by a Physician licensed pursuant to the California Business and Professions Code or is developed by a licensed 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 Qualified Autism Service Provider and administered by one of the following:
  - a Qualified Autism Service Provider.
  - a Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
  - a 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 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 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 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 either of the following:
  - purposes of providing (or for the reimbursement of) respite, daycare, or educational services.
  - to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or in a group or individual therapy session.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management includes methadone maintenance treatment.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.
- Inpatient detoxification for withdrawal symptoms.

If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health /Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

The Mental Health /Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health /Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

22. Obesity - Weight Loss Surgery

Services are covered when Medically Necessary and Prior Authorized. We will use evidence-based criteria to determine coverage of Obesity - Weight Loss 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 the number on your ID card for additional information.

23. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

24. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility or Physician's office.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Combined Evidence of Coverage and Disclosure Form*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card. Your provider may request an exception to the step therapy requirements if they believe the drug is contraindicated or is not consistent with standard medical practice, or have indicated you have previously tried and failed the alternatives

25. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

26. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient.*

27. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

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.

28. Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

29. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass 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 have a beneficial effect on 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.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration* and the Periodicity Schedule of the *Bright Futures Recommendations for Pediatric Preventive Health Care and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*

including well-woman visits (including routine prenatal obstetrical office visits); gestational diabetes screening; human papillomavirus (HPV) DNA testing for women 30 years and older every 3 years; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus (HIV); breastfeeding support and counseling; breast pump purchase of personal pump and supplies; and screening and counseling for interpersonal and domestic violence.

- With respect to women, all Food and Drug Administration (FDA) approved contraceptive methods including drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the Member's Network Provider, voluntary sterilization procedures, and patient education and counseling on contraception and follow-up services related to the drugs, devices, products, and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

  Where FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, we are only required to cover at least one therapeutic equivalent without cost sharing. If a contraceptive is prescribed for other than contraceptive purposes, the Co-payment at the applicable prescription drug tier will apply.

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

- 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 Network Provider. 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:
  - Four Tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
  - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment plan when prescribed by a health care Provider without prior authorization. Please refer to the Outpatient Prescription Drug Benefit Supplement to the Combined Evidence of Coverage and Disclosure Form for the covered tobacco cessation drugs (both over-the-counter and prescription).

- Tobacco cessation medications (both over-the-counter and prescription) covered at zero cost share when prescribed and prior authorized. In addition, you must take part in tobacco cessation counseling sessions as described above. Please call Customer Service for more information.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com or the telephone number on your ID card.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of purchase or rental.

30. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.

Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies.*

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Combined Evidence of Coverage and Disclosure Form.* As an example, internal prosthetic such as pacemakers and hip joints, if they are implanted during a surgery, are covered under *Hospital - Inpatient Stay*.

If more than one item is clinically appropriate to meet the specifications for your needs, but one is less expensive, Benefits are available only for the less expensive item.

Benefits for prosthetic devices to restore a method of speaking for a Member incident to laryngectomy are covered. This includes the initial and subsequent prosthetic devices, including installation accessories, as ordered by a Physician and surgeon. Electronic voice producing machines are not covered.

Prosthetics including original and replacement devices when devices are prescribed by a Physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license are a Covered Health Care Service.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations, under Devices, Appliances and Prosthetics*.

31. Reconstructive Procedures

Reconstructive procedure 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 procedure 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, as

applicable, or UnitedHealthcare in agreement with standards of care as practiced by Physicians specializing in reconstructive surgery.

32. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Benefits can be discontinued when the treatment goals and objectives are achieved or no longer appropriate.

Rehabilitation services must be performed by a Physician or by 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 include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

33. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Skilled nursing will be provided as Medically Necessary based upon limits provided in the Schedule of Benefits. If a Member does not require acute hospital care but intensive skilled nursing is determined to be medically necessary. 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 Prior Authorized by the Member's Network or by UnitedHealthcare.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

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 commence a benefit period.

35. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

36. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).

- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

37. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

38. Transplantation Services

Organ and tissue transplants including CAR-T cell therapy when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.

- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

39. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

40. Urinary Catheters

Benefits for urinary catheters you may require due to incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

41. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio only technology for treatment of acute but non-emergency medical needs

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

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

42. Vision Exams

Routine vision exams received from a health care provider in the provider's office. Routine vision exams include refraction to find vision impairment.

Benefits for eye exams required for the diagnosis and treatment of a health condition are provided under *Physician Office Services*.

Other Benefits

43. Dental Anesthesia Services

Anesthesia and associated facility charges for dental procedures provided in a Hospital or Outpatient surgery center are covered when: (a) the Member's clinical status or underlying medical condition requires use of an Outpatient surgery center or Inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a Hospital or Outpatient surgery center setting; and (b) one of the following criteria is met:

- The Member is under seven years of age;
- The Member is developmentally disabled, regardless of age; or
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

Services for the diagnosis or treatment of a dental disease are not Covered Health Care Services.

44. Mastectomy Services

Coverage for mastectomies and lymph node dissections is provided in the same manner as other covered surgeries. The length of Hospital stay is determined by the attending Physician in consultation with the patient. We will not require the attending Physician to obtain prior approval of the length of the Hospital stay. The Agreement covers all complications from a mastectomy including lymphedema. The Agreement covers prosthetic devices and reconstructive surgery to restore and achieve symmetry for the patient, subject to the Agreement 's deductible and co-payment requirements.

45. Off-Label Drug Use and Experimental or Investigational Services

Off-label drug use means that a Physician or provider has prescribed a drug approved by the Food and Drug Administration *(FDA)* for a use that is different than for which the *FDA* approved the drug. If a drug is prescribed for off-label drug use, the drug and administration will be a Covered Health Care Service only if it satisfies the following criteria:

- The drug is approved by the *FDA*.
- The drug is prescribed by a Network Physician or provider for the treatment of a seriously debilitating or Life-Threatening condition.
- The drug is Medically Necessary to treat the medical condition.
- The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information;* (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex;* or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional 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. However, there is no coverage for

any drug that the *FDA* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Benefits for Experimental or Investigational Services are limited to the following:

- Clinical trials for which Benefits are available as described under *Clinical Trials* above.
- If you are not a participant in a qualifying clinical trial, as described under Clinical Trials above, and have a health condition that is likely to cause death within one year of the request for treatment, we may consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that health condition. Prior to such a consideration, we must first establish that the member has a life-threatening or seriously debilitating condition, and there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that health condition.

Nothing in this section shall prohibit us from use of a formulary, Co-payments or Co-insurance, 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 associated with the administration of a drug subject to the conditions of this Agreement.

If Benefits are denied as an Experimental, Investigational Service, the Covered Person may appeal the decision through independent external medical review as described under Denial of *Experimental, Investigational Services* in *Section 6: Questions, Complaints and Appeals*. You may also call the telephone number on your ID card.

46. Osteoporosis Services

Services related to diagnosis, treatment, and appropriate management of osteoporosis. Services include, but are not limited to, all *FDA* -approved technologies and bone mass measurement. (Benefits for osteoporosis screening are described under *Preventive Care Services*.)

47. Telehealth Services

Benefits are available for applicable Covered Health Care Services received through telehealth. No in-person contact is required between a licensed health care provider and a Covered Person for Covered Health Care Services appropriately provided through telehealth, subject to all terms and conditions of the Agreement.

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

We shall not require the use of telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

Telehealth services do not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under *Virtual Care Services*.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Agreement.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

These exclusions or limitations do not apply to medically necessary services to treat an SMI or SED.

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*).

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under *Dental Anesthesia Services* in *Section 1: Covered Health Care Services.*

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Agreement, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums except as described under *Dental Anesthesia Services* in *Section 1: Covered Health Care Services.* Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Care Services.*

3. Dental implants, bone grafts and other implant-related. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Care Services.*

4. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to services provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies, Specialized Footwear and Orthotic Benefit in Section 1: Covered Health Care Services.*

3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery and/ or to facilitate a successful surgical outcome.

4. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

5. Devices and computers to help in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Care Services* except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

   The exclusion does not apply to services provided under durable medical equipment, special footwear and the orthotic benefit.
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
9. Powered and non-powered exoskeleton devices.

D. Drugs

Please refer to the Exclusions and Limitations under *Prescription Drug Products Covered by Your Benefit* of your *Outpatient Prescription Drug Schedule of Benefits*. The same Exclusions and Limitations will apply to *Pharmaceutical Products*.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in Section 1: Covered Health Care Services.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to

another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational Services

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

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services* and *Off-Label Drug Use and Experimental and Investigational Service* in *Section 1: Covered Health Care Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

6. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under *Specialized Footwear* in *Section 1: Covered Health Care Services*.

7. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under *Specialized Footwear* and under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*

8. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under *Specialized Footwear* and under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*

9. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under *Specialized Footwear* and under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies in Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

H. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not identified in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to Covered Health Care 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 health care professional and are provided by a Network provider acting within the scope of his or her license or as authorized under California law.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Non-Medical 24-Hour Withdrawal Management.

7. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers. This exclusion does not apply to batteries for home blood glucose monitors and infusion pumps as described under *Durable Medical Equipment* in *Section 1: Covered Health Care Services.*
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.

- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for spider veins except if medically necessary.
   - Sclerotherapy treatment of veins except if medically necessary.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure; however, Medically Necessary services related to complications for a non-covered cosmetic procedure are covered. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility except when such exercise programs are part of an authorized treatment plan and require the supervision of a licensed physical therapist, and are provided by an authorized providing acting within his or her license or as authorized under California law.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded except as described under *Obesity-Weight Loss Surgery* in *Section 1: Covered Health Care Services*.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

2. Rehabilitation services for speech therapy that is not medically necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of Network provider acting within the scope of his or her license under California law that is intended to address speech impediments.

3. Biofeedback, 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.

4. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to Medically Necessary services described in *Reconstructive Procedures* and *Temporomandibular Joint (TMJ) Services* under *Section 1: Covered Health Care Services*.

5. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under *Other Health Education Services for You* in the section of the *Combined Evidence of Coverage and Disclosure Form* titled *Our Responsibilities*. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.

6. Helicobacter pylori *(H. pylori)* serologic testing except Medically Necessary consistent with professional practice.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

N. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Medically Necessary standard fertility preservation services when a necessary medical treatment may directly or indirectly cause Iatrogenic Infertility.

2. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. This exclusion does not apply when the surrogate mother is a Member.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to Medically Necessary standard fertility preservation services when a necessary medical treatment may directly or indirectly cause Iatrogenic Infertility.

4. The reversal of voluntary sterilization.
5. In vitro fertilization regardless of the reason for treatment.
6. Insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatments(s) or unless the Member conceives, Gamete Intrafallopian Transfer (GIFT) services in excess of three cycles or one live birth per Member's lifetime are not covered

O. Services Provided under another Plan

1. Any services that the Member receives from a local, state or federal government agency, except when coverage under this Plan is expressly required by federal or state law.
2. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health care services during active military duty.

P. Transplants

1. If deemed experimental, health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Agreement.)
2. Health care services for transplants involving permanent mechanical or animal organs.
3. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.

Q. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services to treat Emergency Medical Condition or Urgent.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.* Also, the exclusion does not apply to qualified transportation costs as described under the Benefit Interpretation Policy Manual as to transportation relating to Gender Dysphoria at **www.myuhc.com**.

R. Types of Care

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
5. Rest cures.
6. Services of personal care aides. This exclusion does not apply to hospice care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.

2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Agreement.

   Repairs and/or replacement for the implanted components of a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which meet the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Combined Evidence of Coverage and Disclosure Form* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Evidence of Coverage* under *Section 2: Exclusions and Limitations*.
   - As otherwise required to be covered under the law.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Agreement when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received after the date your coverage under the Agreement ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Agreement ended.
4. Health care services the Member receives from a local, state or federal government agency except when coverage under this Health Plan is expressly required by federal or state law.
5. Charges in excess of the Allowed Amount or in excess of any specified limitation.

6. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

7. Autopsy.

8. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. This exclusion does not apply to interpretive services available in UnitedHealthcare Benefits Plan of California's language assistance program as required by California law.

9. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage. Please refer to your employer group for more information about contribution and amounts.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Agreement.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Agreement.

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

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Agreement from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Agreement. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

All newborn Dependent children of the Subscriber are covered from the moment of birth. All newly adopted Dependent children of the Subscriber are covered from and after the moment the child is placed in the physical custody of the Subscriber for adoption. However, the Subscriber must complete an enrollment form for all newborn and all newly adopted Dependent children within 60 days of the event.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form within 60 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.
- Assumption of a Parent-Child Relationship or Guardianship.

Late Enrollment

In addition to a special enrollment period there are circumstances when an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period may enroll if:

- 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;
- We 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 us 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.
- The other health care coverage is no longer available due to:
  - The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or
  - The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
  - The termination of the other Health Plan coverage; or
  - The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
  - The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered;
  - 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
  - The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or
  - 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
  - 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.

- 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. We 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.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Agreement and/or all similar benefit plans at any time for the reasons explained in the Agreement.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Agreement Ends**

  Your coverage ends on the date the Agreement ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

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.

Termination of Coverage

We have the right to terminate your coverage under this Health Plan in the following situations:

- **For Nonpayment of Premiums.** Your coverage may be terminated if the Employer Group did not pay the required Premiums.

  We will mail your employer a Notice of Start of Grace Period, no later than five (5) business days after the last day of paid coverage. The premium amount must be paid not later than 30 days from the date of the Notice.

- If payment is not received from your employer within 30 days of the date the Notice of Grace Period, coverage will be cancelled and we mail you a Notice of End of Coverage.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice of cancellation, rescission or nonrenewal to the Group that coverage will end on the date we identify in the notice because you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Agreement.

Under no circumstances will a Member be terminated due to health status or the need for health care services. 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.

Notice

When we provide written notice regarding administration of the Agreement to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

We will provide notice to the Enrolling Group and all affected Subscribers if either of the following occurs:

- For discontinuance of a particular health benefit plan. Your coverage may be terminated if we decide to cease offering a particular health benefit plan upon 90 days prior written notice to the California Department of Managed Health Care, the Group and all affected Subscribers covered under the health benefit plan. When a health benefit plan is discontinued, we will make all other health benefit plans offered to new group business available to the Group without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.

- For discontinuance of all new and existing health benefit plans. Your coverage may be terminated if we decide to cease offering existing or new plans in the group market in the State of California upon 180 days prior written notice to the California Department of Managed Health Care, the Group and all affected Subscribers covered under the health benefit plans.

Continuing Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached 26 years old, the Limiting Age. We will extend the coverage for that child beyond the Limiting Age if both of the following are true:

- The Enrolled Dependent child is not able to support himself/ herself because of a physically or mentally disabling injury, illness or condition.
- The Enrolled Dependent child depends mainly on the Subscriber for support and maintenance.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Agreement. At least 90 days prior to a disabled Dependent reaching the Limiting Age, we 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 us. You must furnish us with proof of the medical certification of disability within 60 days of the date of receipt of our notice the child reached the Limiting Age. We will decide if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until we make a determination.

We 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, we 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 us 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.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Agreement ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Agreement ends.

Continuation of Coverage

If your coverage ends under the Agreement, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state 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*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Agreement, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you 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 you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has happened. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, legal spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Health Plan), the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event happens. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

Notification Requirements and Election Period for Continuation Coverage under State Law (AB 1401)

The Group will provide you with written notification of the right to continuation coverage within 30 days of when coverage ends under the Agreement. You must elect continuation coverage within 90 days of receiving this notification. You should get an election form from us and, once election is made, forward all monthly Premiums to us for payment to us.

Terminating Events for Continuation Coverage under State Law (AB 1401)

Continuation coverage under the Agreement will end on the earliest of the following dates:

- 36 months from the date your qualifying event.
- The date after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare.
- The date after electing continuation coverage that the Qualified Beneficiary has other hospital, medical or surgical coverage, or is or becomes covered under another group health plan.
- The date the Qualified Beneficiary is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act.
- The date coverage terminated under the Agreement for failure to make timely payment of the Premium.
- The date the Agreement ends.
- The date coverage would otherwise terminate under the Agreement as described in this section under the heading Events Ending Your Coverage.

Continuation Coverage for Surviving Dependents of Fire Fighters and Peace Officers

Eligibility

If a Subscriber is a firefighter or peace officer who dies in the line of duty, the Enrolled Dependent(s) are eligible for continuation of coverage upon the next renewal as determined by the Enrolling Group.

A firefighter or peace officer who dies in the line of duty is defined by California law as a person who:

- Is killed in the performance of his or her duty, or

- Dies as a result of an accident or injury caused by external violence or physical force incurred in the performance of his or her duty.

Until the next renewal period, the coverage will be the same benefits that the Dependent spouse and children had while the firefighter or peace officer was alive. Dependent children will receive benefits under the coverage provided to the surviving spouse. If there is no surviving spouse, coverage for Dependent children will continue until the age of 21 years.

Exemption to Continuation Coverage

This provision does not apply if the surviving spouse elects to receive a lump sum survivor's benefit in lieu of monthly benefits.

Notification Requirements and Election Period

The Enrolling Group shall provide applicable Enrolled Dependents with written notification of the right to continuation coverage and the Enrolled Dependents must elect continuation coverage within 31 days of receiving notification. Enrolled Dependents should obtain an election form from the Enrolling Group and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events

Continuation Coverage under the Agreement will end on the earliest of the following dates:

- The date an individual is covered under any group health plan not maintained by the Enrolling Group, regardless of whether that coverage is less valuable; or
- The date an individual no longer resides in California; or
- The date coverage terminates because the individual violates a material condition of the Agreement; or
- The date a Dependent child is no longer eligible.

If a surviving spouse remarries, coverage for the surviving spouse and Dependent children of the deceased firefighter or peace officer will continue, but the surviving spouse may not add the new spouse or stepchildren as eligible Dependents under the Agreement.

Special Provisions for Union Employee if Work Stops due to a Labor Dispute

If some or the entire Premium for the Agreement is paid by the Enrolling Group under the terms of a collective bargaining agreement, this provision will apply to Subscribers whose employment is covered by the agreement.

Work may stop due to a labor dispute. The Agreement and all insurance will continue during the dispute as long as Premium is paid to us. Continuation is subject to the other sections of this provision.

Insurance will continue under this provision only for those Subscribers who are insured on the date work stops who continue to pay their contributions and also assume and pay the Enrolling Group's contributions. The Enrolling Group will send the contributions to us.

The Union that represents the Subscribers will collect the Subscribers' contributions. At least 75% of the Subscribers who were in the collective bargaining unit on the date work stopped must be making contributions. The Union will send the contributions to us.

Insurance coverage will continue as long as we receive Premium payments on or before each due date, subject to the grace period and the next paragraph.

If any Premium payment was due but had not been paid at the time work stopped, insurance will continue under this provision only if the Enrolling Group pays that overdue Premium before the next Premium due

date. If we accept Premium from the Enrolling Group more than 31 days after the Premium due date, we will accept Premium for the same period of time from the Union representing the Subscribers.

The Subscribers' contributions per month that work is stopped will be figured as follows and will be increased as stated in the next paragraph:

- The Premium rates for the Agreement on the date work stops may be stated as a set amount per Subscriber. Each Subscriber's contribution will be the rate or rates for the Subscriber's group.
- The Premium rates may not be stated as a set amount per Subscriber. Each Subscriber's contribution will be an average rate figured from the Agreement 's Premium rates and the amounts of insurance shown in Exhibit 2.

During the period that work is stopped each separate Premium rate in effect on the date work stops will be increased by 20%. Each Subscriber's contribution will be increased by 20%. We may agree to a smaller increase.

We will still have the right to increase or decrease Premium rates at any time in accordance with the terms of the Agreement. We will have this right at any time that we would have had this right if work had not stopped. If we change the Premium rates, the change will be effective in accordance with the terms of the Agreement regardless of any other sections of this provision.

Insurance will continue according to this provision until the earliest of the following:

- The date stated in a notice from us to the Union. A notice will be sent when less than 75% of the Subscribers who were in the collective bargaining unit on the date work stopped are insured.
- The date the Subscriber is employed by an employer other than the Enrolling Group.
- 6 months after the date work stopped.

This provision can be extended to apply to other groups of Subscribers away from work due to a labor dispute if we agree.

Continuity of Care

If you are undergoing a course of treatment with a terminated Network provider for one of the medical conditions below, we may arrange, at your written request and subject to the Network provider's written agreement to accept the same contractual terms and conditions that were imposed upon the Network provider, prior to termination, for continuation of Covered Health Care Services rendered by the terminated Network provider for the time periods shown below. We must receive your request for Continuity of Care as soon as possible, but not later than 30 calendar days from the date you are notified in writing that your Network provider has been terminated. Co-payments, deductibles or other cost sharing components will be the same as you would have paid for a provider currently contracting with us. Exceptions to the 30 calendar day time frame will be considered for good cause. Continuity of Care forms are available by calling Customer Service.

Continuity of Care for Covered Health Care Services may be provided by a terminated Network provider to a Member who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described below.

Medical conditions and time periods for which treatment by a terminated Network provider may be covered under the Policy are:

- **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a health condition 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.
- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, health condition, 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. Completion of Covered Health Care Services will be

provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Network provider, in consultation with you and the terminated Network provider or out-of-network provider and consistent with good professional practice. Completion of Covered Health Care Services under this provision will not exceed 12 months from termination date of the provider's agreement or 12 months from the effective date of coverage for the new Member when criteria are met.

- **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 Health Care Services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later. For purposes of this section, "maternal mental health condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri of postpartum period, up to one year after delivery.

- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Care Services will be provided for the duration of a terminal illness, which may exceed 12 months from the termination date of the provider's agreement or 12 months from the effective date of coverage for a new Member when criteria are met.
- **The care of a newborn child between birth and age 36 months.** Completion of Covered Health Care Services will not exceed 12 months from the termination date of the provider's agreement or 12 months from the effective date of coverage for a new Member when criteria are met.
- **Performance of a surgery or other procedure.** Performance of a surgery or other procedure that has been recommended and documented by the Network provider to occur within 180 days of the termination date of the provider's agreement or within 180 days of the effective date of coverage for a new Member when criteria are met.

This section does not apply to treatment by a provider or provider group whose contract with us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

In the event of carrier replacement, Continuity of Care for Covered Health Care Services may be provided by an out-of-network provider to a new Member who, at the time of his or her coverage became effective, was receiving services from that provider for one of the conditions described above under your out-of-network benefit. A completed Continuity of Care form must be received by UnitedHealthcare, but no later than 30 days from your effective date of coverage. Exceptions to the 30-calendar day time frame will be considered for good cause.

For Continuity of care to apply to an out-of-network provider that is treating you for a condition outlined above, UnitedHealthcare may require your out-of-network provider whose services are continued for a newly covered member to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting Network providers providing similar services who are not capitated and who are practicing in the same or similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the out-of-network provider does not agree to comply or does not comply with these contractual terms and conditions, UnitedHealthcare is not required to continue the provider's services and your request for Continuity of Care may be denied.

In the event you elect to continue to receive services by a terminated Network provider or from an out-of-network provider without receiving prior authorization from us, you may be financially responsible for the payment of all claims

Appealing a Termination

If you believe that we terminated your membership improperly, you may file a grievance to appeal the decision. Please refer to *Section 6, Questions, Complaints and Appeals*. You may also request the Department of Managed Health Care to review your termination.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable Deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service or as soon as reasonably possible, of receiving services and related supplies. If you don't provide this information to us within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

After we receive your claim, we will send an acknowledgement letter within 5 days from receipt of the claim.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum RX

PO Box 29077

Hot Springs, AR 71903

Payment of Benefits

We will pay Benefits within 45 days after we receive your request for payment that includes all required information. We will reimburse claims or any portion of any claim, whether in-state or out-of-state, for

Covered Health Care Services, as soon as possible, no later than 45 working days after receipt of the claim. However, a claim or portion of a claim may be contested or denied by us. In that case you will be notified in writing that the claim is contested or denied within 45 working days of receipt of the claim. The notice that the claim is being contested or denied will identify the portion of the claim that is contested or denied and the specific reasons including, for each reason, the factual and legal basis known at the time by us for contesting or denying the claim. If the reason is based solely on facts or solely on law, we will provide only the factual or the legal basis for contesting or denying the claim. We will provide a copy of such notice to each Member who received services pursuant to the claim that was contested or denied and the health care provider that provided the services at issue.

If an uncontested claim is not reimbursed by delivery to your address of record within 45 working days after receipt, we will pay interest at the rate of 15% per annum beginning with the first calendar day after the 45-working-day period.

If a Subscriber provides written authorization to allow this, all or a portion of any Allowed Amount due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Assignment of Benefits

You may not assign your Benefits under the Agreement or any cause of action related to your Benefits under the Agreement to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Agreement to an out-of-Network provider with our consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.

Payment of Benefits under the Agreement shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

All complaints and appeals will be reviewed and resolved by us including any relating to acupuncture and mental health Substance-Related and Addictive Disorders. To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address or you can visit www.myuhc.com.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

What to Do if You Disagree with Our Adverse Benefit Determination?

If you disagree with our Adverse Benefit Determination, you may file a formal appeal. Our internal review appeals procedures are designed to deliver a timely response and resolution to your appeal. We will continue to provide coverage for the Covered Health Care Service under review until the Adverse Benefit Determination is resolved.

An Adverse Benefit Determination is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Service or not Medically Necessary or appropriate. An adverse benefit determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

If you believe your Subscriber Agreement has been or will be wrongly canceled, rescinded or not renewed, please refer to Cancellation, Rescission or Non-Renewal in this Section to learn how to request a review by the Department of Managed Care (DMHC) Director.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal 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 denial of a pre-service request for Benefits or the claim denial.

To initiate an appeal or request, call the telephone number on the ID card, where a Customer Care representative will document your oral appeal. You may also file an appeal using the Online Grievance form at www.myuhc.com.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen 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 expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed 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 related to your claim for Benefits. 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 in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

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

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available and Medically Necessary under the Agreement for the proposed treatment or procedure. For appeals involving the denial or modification of health care services related to Medical Necessity, UnitedHealthcare Benefits Plan of California'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 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 Subscriber Agreement that exclude that coverage.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Pre-Service Requests Determination Based on Medical Necessity

Decisions to deny or modify requests for authorization of Covered 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 Covered 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 our 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 our 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:

- We are not in receipt of all of the information reasonably necessary and requested; or
- Consultation by an expert reviewer is required; or
- 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 Physician and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as we become 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 us, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

Concurrent Care Review

If an on-going course of treatment was previously approved and a request is made to extend treatment, if urgent, your request will be decided in a timely manner appropriate for the nature of your condition not to exceed 72 hours from receipt.

If the request to extend treatment is not an Urgent Request for Benefits, your request will be decided in a timely manner medically appropriate for the nature of your condition not to exceed five (5) business days. Care will not be discontinued until your treating provider has been notified of our decision and a care plan has been agreed upon by your treating provider that is appropriate for your medical needs.

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 and an opportunity for advance review. and a care plan, and a medically appropriate treatment plan agreed between us 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 Benefits Plan of California. 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 Benefits Plan of California's Appeals Process is outlined in this section.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

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 Benefits Plan of California'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 Benefits Plan of California 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 Benefits Plan of California appeals process prior to contacting the DMHC regarding your expedited appeal.

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 Care at 1-800-260-2773, or at www.myuhc.com. A Customer Care representative will document your oral grievance. You may also file grievance using the Online Grievance form at www.myuhc.com or write to the Appeals department at:

Appeals & Grievances

UnitedHealthcare Benefits Plan of California

P.O. BOX 30573

Salt Lake City, UT 84130-0573

This request will initiate 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 acknowledgement within five calendar days of the receipt of your grievance. The acknowledgment shall provide you with the following information:
  - That the grievance has been received.
  - The date of receipt
  - The name of the Plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

All quality of clinical care and quality of service complaints are investigated by UnitedHealthcare Benefits Plan of California's Health Services department. UnitedHealthcare Benefits Plan of California conducts this quality review by investigating the complaint and consulting with your treating providers, and other UnitedHealthcare Benefits Plan of California 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 Benefits Plan of

California'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.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with UnitedHealthcare Benefits Plan of California's Appeal Process determination, you can request that we 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 us. 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 Benefits Plan of California, 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 Benefits Plan of California 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 Benefits Plan of California 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 Benefits Plan of California. The expenses of JAMS and the arbitrator will be paid in equal shares by the Member and UnitedHealthcare Benefits Plan of California. 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 Benefits Plan of California 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 his/ her 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 Benefits Plan of California 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.

Independent Medical Review

If you believe that a health care service included in your coverage has been improperly denied, modified or delayed by UnitedHealthcare Benefits Plan of California, 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 Benefits Plan of California'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.

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 Benefits Plan of California than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.
2. Either (a) your 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-Network 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 Benefits Plan of California is not responsible for the payment of services rendered by Non-Network Physicians who are not otherwise covered under your UnitedHealthcare Benefits Plan of California benefits).
3. A UnitedHealthcare Benefits Plan of California 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 Health Care Service, except for UnitedHealthcare Benefits Plan of California'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 Benefits Plan of California denies your request for Experimental or Investigational therapy, UnitedHealthcare Benefits Plan of California 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 Subscriber Agreement that has been denied, modified or delayed in whole or in part by UnitedHealthcare Benefits Plan of California or one of its providers, 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 Medical Condition 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 Benefits Plan of California or one of its providers; and
3. You have filed an appeal with UnitedHealthcare Benefits Plan of California regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the appeal remains unresolved after 30 calendar days (or three calendar days in the case of an urgent appeal requiring expedited review). (Note: If there is an imminent and serious threat to your health, the DMHC may waive the requirement that you complete the appeals process or 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 Benefits Plan of California will provide you an IMR application form with any Grievance disposition letter that denies, modifies or delays, in whole or in part, health care services based on 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 Benefits Plan of California 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 Benefits Plan of California 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 Benefits Plan of California or its 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 Benefits Plan of California 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 Benefits Plan of California or its 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 UHCBP of CA, 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 (IMR) organization contracted with the DMHC for review by one or more expert reviewers, independent of UnitedHealthcare Benefits Plan of California, who will make an independent determination of whether or not the care should be provided. The IMR 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 Benefits Plan of California will control the choice of expert reviewers.

UnitedHealthcare Benefits Plan of California must provide the following documents to the IMR organization 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 Benefits Plan of California or its providers;
2. All information provided to you by UnitedHealthcare Benefits Plan of California and any of its providers concerning UnitedHealthcare Benefits Plan of California and provider decisions regarding your condition and care (including a copy of UnitedHealthcare Benefits Plan of California's denial notice sent to you);
3. Any materials that you or your provider submitted to UnitedHealthcare Benefits Plan of California and its providers in support of the request for the health care services;
4. Any other relevant documents or information used by UnitedHealthcare Benefits Plan of California or its providers in determining whether the health care service should have been provided and any statement by UnitedHealthcare Benefits Plan of California or its 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 Benefits Plan of California will deliver the necessary information and documents listed above to the IMR organization within 24 hours of approval of the request for IMR.

After submitting all of the required material to the IMR, UnitedHealthcare Benefits Plan of California 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 Benefits Plan of California.

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 Benefits Plan of California, 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 IMR 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-Formulary Drugs

If a Member objects to a disapproval of a prior authorization request of a "non-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. We will respond to the review within 24 hours of receipt by us 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 DMHC.

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 IMR will provide the DMHC, you and your Physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IMR 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 Benefits Plan of California, 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 Benefits Plan of California will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IMR upon receipt and will promptly issue a written decision to the parties that will be binding on UnitedHealthcare Benefits Plan of California. UnitedHealthcare Benefits Plan of California will promptly implement the decision when received from the DMHC. In the case of an IMR determination requiring reimbursement for services already rendered, UnitedHealthcare Benefits Plan of California will reimburse either you or your provider - whichever applies - within five business days. In the case of services not yet rendered to you, UnitedHealthcare Benefits Plan of California 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 Benefits Plan of California will promptly reimburse you for reasonable costs associated with Urgently Needed Services or Emergency Medical Condition outside of UnitedHealthcare Benefits Plan of California's provider network, if:

- The services are found by the IMR to have been Medically Necessary;
- The DMHC finds your decision to secure services outside of UnitedHealthcare Benefits Plan of California's provider network prior to completing the UnitedHealthcare Benefits Plan of California 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 Subscriber Agreement.

Health care services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under your UnitedHealthcare Benefits Plan of California Health Plan.

For more information regarding the IMR process, or to request an application, please call UnitedHealthcare Benefits Plan of California's Customer Care department.

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 1-800-260-2773 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.

Grievances Involving the Cancellation, Rescission or Non-Renewal of Subscriber Agreement

If you believe that your enrollment or Subscriber Agreement has been, or will be improperly rescinded, canceled, or not renewed, you have the right to file a complaint. You have the options of going to us and/or the DMHC if you do not agree with our decision to cancel, rescind or not renew your plan coverage. You may want to submit a review first to us if you believe the cancellation, rescission or nonrenewal was the result of a mistake.

You can file a complaint with UnitedHealthcare Benefits Plan of California by calling our Customer Care at 1-800-260-2773 or visiting www.myyhc.com.

- You should file your complaint as soon as possible after you receive notice that your enrollment or Subscriber Agreement will be rescinded, canceled or not renewed.
- UnitedHealthcare Benefits Plan of California must give you a decision within 3 calendar days from receipt of your complaint regardless of whether your complaint is urgent or not. The Plan will provide its decision through a notice sent to you and the DMHC.
- If your problem is not urgent, UnitedHealthcare Benefits Plan of California must give you a decision within 30 days. You have at least or up to 180 days from the date of the notice to submit a grievance to the Plan when you think there is improper cancellation, rescission or non-renewal.

Take your complaint to the California Department of Managed Health Care (DMHC)

The DMHC oversees health care service plans in California licensed by the Department and protects the rights of members. You can file a complaint with the DMHC instead of the Plan whether it is urgent or not.

The DMHC oversees health care service plans in California licensed by the Department and protects the rights of members. You can file a complaint with the DMHC instead of the Plan whether it is urgent or not. If a proper complaint exists, the DMHC shall give notice to the Member and to us that it has been accepted within 48 hours of the determination that the complaint is proper. Within 30 calendar days of receipt or longer, if needed, the Director will send notice of its determination to the Member and to us.

For Help

Contact the DMHC Help Center at the toll-free telephone number **(1-888-466-2219)** to receive assistance with this process, or submit an inquiry in writing to the **DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725** or through the website: **http://www.dmhc.ca.gov**. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-877-688-9891 (TTY)**.

If you have a complaint or grievance relating to Mental Health and Substance-Related and Addictive Disorder Services, you can submit it to U.S. Behavioral Health Plan, California (USBHPC), see the behavioral supplement to your Combined Evidence of Coverage Form for USBHPC.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Agreement will be coordinated with those of any other plan that provides benefits to you. The language in this section is based on California regulations.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its Agreement terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. 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.

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.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage

under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense.** Allowable Expense is a health care expense, including Deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount 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 or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care 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 excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of 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. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by 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.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

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. We may get the facts we need 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.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We 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" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Allowed Amount for the service or item.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Agreement and how it may affect you. We help finance or administer the Group's Agreement in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Agreement will cover or pay for the health care that you may receive. The Agreement pays for Covered Health Care Services, which are more fully described in this *Combined Evidence of Coverage and Disclosure Form*.
- The Agreement may not pay for all treatments you or your Physician may believe are needed. If the Agreement does not pay, you will be responsible for the cost.

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

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

The relationships between us and Network providers and Groups are solely contractual relationships between independent contractors. Network providers and Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Groups.

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

We will provide you with written notice within a reasonable time of any termination or breach of a Network Provider's contract if you may be materially and adversely affected by such termination or breach.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Agreement. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Agreement.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Agreement Charge to us.
- Notifying you of when the Agreement ends.

When the Group purchases the Agreement to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any Deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Agreement.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group or by a Subscriber to void the Agreement including fraud or an intentional misrepresentation of a material fact, after twenty-four (24) months from the date of issuance of the Agreement.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Liability of Subscriber for Payment

Members will not be required to pay any Network provider for amounts owed to that provider by UnitedHealthcare Benefits Plan of California (other than Co-payments/Co-insurance), even in the unlikely event that UnitedHealthcare Benefits Plan of California fails to pay the provider. Members are not financially responsible for payment of Emergency Health Care services, beyond the Co-payments, Co-insurance, and Deductibles as provided in this Agreement. Members are liable, however, to pay Non-Out-of-Network providers for any and all amounts owed to those providers not covered or excluded as provided in this Agreement.

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.

Are Incentives Available to You?

Sometimes we may offer enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.myuhc.com or the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Deductible. We will account for any rebates and other retrospective cost and pricing arrangements for outpatient prescription drugs by verifying that the rebates and other retrospective cost and pricing arrangements for outpatient prescription drugs are applied by us to reduce your cost.

Who Interprets Benefits and Other Provisions under the Agreement?

We have the final authority to do all of the following:

- Interpret Benefits under the Agreement.
- Interpret the other terms, conditions, limitations and exclusions set out in the Agreement, including this *Combined Evidence of Coverage and Disclosure Form*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Agreement and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Agreement.

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

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, 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 as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Agreement

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end the Agreement with a 60-day advance notice.

Any provision of the Agreement which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Agreement is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Agreement unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Agreement are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Agreement or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Agreement.

How Do We Use Information and Records?

We will protect the privacy of protected health information. We also require Network providers to protect your protected health information. Protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. We may use your individually identifiable health information as follows:

- To administer the Agreement and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Agreement, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential. Except as compelled by law such as for judicial actions, we may not disclose confidential medical information for Members without first obtaining a signed authorization. Please refer to our *Notice of Privacy Practices* that includes information on obtaining written consents and revocations.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Agreement.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Agreement, we and our related entities may use and transfer the information gathered under the Agreement in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

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

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

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Does UnitedHealthcare Offer a Translation Service?

UnitedHealthcare uses a telephone translation service for almost 140 languages and dialects. That's in addition to choosing to call Customer Service representatives who are fluent in Spanish. Translated Member materials are available upon request. Interpretation services may also be available at the Network Provider office. Please contact the Network Provider for specific language interpretation availability.

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 (TTY).

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 Network providers 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 later provide appropriate reimbursement.

Nondiscrimination Notice

We do 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 provider 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 6.

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 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.

Public Policy Participation

UnitedHealthcare Benefits Plan of California gives its Members the opportunity to participate in establishing its public policy. At least 51% of the Members of UnitedHealthcare Benefits Plan of California's Public Policy Committee are Subscribers/Members. If you are interested in participating in the establishment of UnitedHealthcare Benefits Plan of California's public policy, please call Customer Care at the telephone number on your ID card.

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

Any demand upon a Member will be in accordance with California Civil Code Section 3040.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Subscriber Agreement, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.

- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Agreement.

The refund equals the amount we paid in excess of the amount we should have paid under the Agreement. If the refund is due from another person or organization, you agree to help us get the refund when requested.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Agreement?

The Agreement, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Agreement that is issued to the Group.

Section 9: Defined Terms

Agreement - the entire agreement issued to the Group that includes all of the following:

- *Group Agreement.*
- *Combined Evidence of Coverage and Disclosure Form.*
- *Schedule of Benefits.*
- Group *Application.*
- Riders, including, but not limited to, Mental Health Substance-Related and Addictive Disorder Services, as applicable.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Agreement Charge - the sum of the Premiums for all Covered Persons enrolled under the Agreement.

Allowed Amounts - for Covered Health Care Services, incurred while the Agreement is in effect, Allowed Amounts are determined by us as shown in the *Schedule of Benefits*.

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

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

- Surgical services.
- Emergency Health Care Services for Emergency Medical Conditions.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Agreement. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Agreement, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - See definition of Severe Mental Illness below.

Benefits - your right to payment for Covered Health Care Services that are available under the Agreement.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

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

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that are performed to alter or reshape normal structures of the body in order to improve appearance.

Covered Health Care Service(s) - health care services, including services, supplies or Pharmaceutical Products, which meet the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Combined Evidence of Coverage* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Combined Evidence of Coverage and Disclosure Form* under *Section 2: Exclusions and Limitations*.
- As otherwise required to be covered under the law.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Agreement. We use "you" and "your" in this *Combined Evidence of Coverage and Disclosure Form* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

This does not apply to Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse or Domestic Partner.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: Coverage for a Disabled Dependent Child.*
- A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that we have identified as Designated Providers. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio and video technology or audio only. A Designated Virtual Network Provider may be a local provider, who offers health care services to a patient population within a fixed or defined geography, or a national care provider, who offers health care services to a patient population within the entirety of the United States, including United States territories.

Domestic Partner - a person who has filed a declaration of domestic partnership with the California Secretary of State or a person who meets the eligibility requirements, as defined by the Enrolling Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons 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.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Agreement. An Eligible Person must live within the United States.

Emergency a serious medical or psychiatric condition or symptom resulting from Injury, Sickness or mental illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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 Covered 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:
  - there is inadequate time to effect 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 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 Member 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 mental disorder.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person s license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility, and
- An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

Enrolled Dependent - a Dependent who is properly enrolled under the Agreement.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Agreement is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Iatrogenic Infertility - an impairment of fertility caused directly or indirectly by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Agreement.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Limiting Age - The age established by the UnitedHealthcare Benefits Plan of California 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.

Manipulative Treatment (adjustment) - a form of care provided by osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- If more than one health intervention equally meets the requirements of the above, but one is more cost effective, the more cost effective one may be furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean the lowest price.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UnitedHealthcareOnline.

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

Member - either the Subscriber Agreement holder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Subscriber Agreement. References to "you" and "your" throughout this Subscriber Agreement are references to a Member.

Mental Health Care Services - Covered Health Care Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

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

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Agreement. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject, from time to time, to our review and change. You may find out which tier a particular Pharmaceutical Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Please Note: Any acupuncturist, audiologist, certified respiratory care practitioner, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Agreement.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

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.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Agreement.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, placing Pharmaceutical Products into specific tiers.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee and operates in accordance with applicable state law for residential treatment programs.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Schedule of Benefits - A part of the Subscriber Agreement and *Combined Evidence of Coverage and Disclosure Form* along with the *Outpatient Prescription Drug Schedule of Benefits,* that provides benefit information specific to your Health Plan, including Co-payment/Co-insurance information.

Rider - any attached written description of additional Covered Health Care Services not described in this *Combined Evidence of Coverage and Disclosure Form*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Agreement except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Serious Emotional Disturbances - Serious Emotional Disturbances of a Child - A Serious Emotional Disturbance (SED) of a Child is defined as a child who:

- Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance-related and addictive disorder, which results in behavior inappropriate to the child's age according to expected developmental norms; and who
- Is under the age of 18 years old; and
- Meets one or more of the following criteria:
  - As a result of the mental disorder, 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 either of the following occur:
    - the child is at risk of removal from home or has already been removed from the home;
    - 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, risk of suicide or risk or violence due to a mental disorder; or
  - The child meets special education eligibility requirement 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.

Service Area - the State of California or any other geographical area within the state designated in the Agreement within which Network provider services are rendered to Covered Members for Covered Health Care Services.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Combined Evidence of Coverage and Disclosure Form* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

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 include 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.

Subscriber - an Eligible Person who is properly enrolled under the Agreement. The Subscriber is the person (who is not a Dependent) on whose behalf the Agreement is issued to the Group.

Substance-Related and Addictive Disorders Services - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the latest edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus to term for another person.

Telehealth - The mode of delivering Covered Health 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 real-time interactions and 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. The originating site and the distant-site are licensed to provide Telehealth according applicable law.

Total Disability or Totally Disabled - 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.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness or Injury.

Urgently Needed Services - Medically Necessary Covered Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

NOTE: THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM PROVIDES A DESCRIPTION OF THE COVERED HEALTH CARE SERVICES AVAILABLE TO YOU UNDER YOUR UNITEDHEALTHCARE BENEFITS PLA OF CALIFORNIA. 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 PROVIDED UPON REQUEST AND IS AVAILABLE AT UNITEDHEALTHCARE AND YOUR GROUP'S PERSONNEL OFFICE.

UnitedHealthcare Benefits Plan of California

Pharmacy Schedule of Benefits

Payment Term And Description	Amounts
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT)	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	$5,000 per Covered Person.
Co-payment	
Your Co-payment is determined by the Prescription Drug List (PDL) Management Committee's Tier placement of a Prescription Drug Product.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Co-payment • The Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment. • A Network Pharmacy's retail price for the Prescription Drug Product. See the Co-payments in the Benefit Information table for amounts. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10.00 per

Payment Term And Description	Amounts
Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $150.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $250.00 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $150.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $250.00 per Prescription Order or Refill
Prescription Drug Products from a Network Retail Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. **You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.** **A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives**. 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.	**Tier 1** Prescription Drug Product $10.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 9: Defined Terms*, for the definition of a High Deductible Health Plan. **Tier 2** Prescription Drug Product $35.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 9: Defined Terms*, for the definition of a High Deductible Health Plan **Tier 3** Prescription Drug Product

Payment Term And Description	Amounts
	$70.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 9: Defined Terms*, for the definition of a High Deductible Health Plan **All cost sharing applies to the out-of-pocket limit.**
Prescription Drug Products from an Out-of- Network Retail Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. **You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.** **A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives**. 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.	**Tier 1** Prescription Drug Product $10.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 9: Defined Terms*, for the definition of a High Deductible Health Plan. **Tier 2** Prescription Drug Product $35.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 9: Defined Terms*, for the definition of a High Deductible Health Plan **Tier 3** Prescription Drug Product $70.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health

Payment Term And Description	Amounts
	Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 9: Defined Terms*, for the definition of a High Deductible Health Plan **All cost sharing applies to the out-of-pocket limit.**
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits as written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. You may be required to fill the first Prescription Drug Product order at a retail pharmacy and obtain 2 refills at a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-payment for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 31-day supply with three refills.	For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay: Tier 1 Prescription Drug Product: **Tier 1** Prescription Drug Product $25.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 9: Defined Terms*, for the definition of a High Deductible Health Plan. **Tier 2** Prescription Drug Product $87.50 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 9: Defined Terms*, for the definition of a High Deductible Health Plan **Tier 3** Prescription Drug Product $175.00 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health

Payment Term And Description	Amounts
	Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, *Section 9: Defined Terms*, for the definition of a High Deductible Health Plan **All cost sharing applies to the out-of-pocket limit.**

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

What Do I Pay When I fill a Prescription?

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

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates will not be available to you.
- Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.
- Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.

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

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

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

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

If A Brand-Name Drug Becomes Available as a Generic

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

Prior Authorization

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

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

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

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

Prior Authorization and Step Therapy Exception Process

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

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

Prescription Drug Products Covered by Your Benefit

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

- **Disposable all-in-one pre-filled insulin pens**, insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior Authorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend**:** "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs**: Comparable Generic drugs may be substituted for Brand-name drugs. For Brand-name drugs that have FDA approved equivalents, a prescription may be filled with a Generic drug unless a specific Brand-name drug is Medically Necessary and Prior Authorized by UnitedHealthcare. Prior Authorization is necessary even if a licensed Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. If you choose to use a Prescription Drug Product not included on the PDL and not Prior Authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication.

  If the requested drug is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your applicable Tier Co-payment.
- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets and lancet devices, inhaler extender devices, urine test strips, ketone testing strips and tablets, glucose meters (including continuous glucose monitors), certain immunizations, and anaphylaxis prevention kits. See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medication and equipment for the treatment of asthma in Section 1: Covered Health Care Services.

- Oral Contraceptives: All FDA-approved contraceptives, drugs, devices, and products are covered at $0 cost sharing subject to Therapeutic Equivalents that may be prescribed and may be subject to Prior Authorization. A Member may receive a 12-month supply of a FDA-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a provider or from a contracted pharmacy that has agreed to dispense or furnish FDA-approved contraceptives in accordance with state and federal law. Over-the-counter birth control devices require a prescription from your provider. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical Evidence of Coverage and to your Outpatient Prescription Drug Supplement for more information.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most Prescription Drug Products, there are some that are not covered or limited. These Prescription Drugs Products are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section 1 of your medical *Combined Evidence of Coverage* and Disclosure Form entitled Covered Health Care Services for more information about medications covered by your medical benefit.

- Administered Prescription Drug Products: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit. Refer to Section 1 of your medical *Combined Evidence of Coverage and Disclosure Form* titled Covered Health Care Services for more information about medications covered under your medical benefit.
- Compounded medication: Any Medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- Diagnostic drugs: Drugs used for diagnostic purposes are not covered. Refer to Section 1 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 Network Physician provided that the diet is Medically Necessary. For additional information, refer to Section 1 of your medical *Combined Evidence of Coverage and Disclosure Form*. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Enhancement medications when prescribed for the following non-medical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer's dementia.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.

- Infertility: All forms of Prescription Drug Products when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, Prescription Drug Products for the treatment of infertility may be covered under that benefit. Please refer to Section 1 of your medical *Combined Evidence of Coverage and Disclosure Form* entitled Covered Health Care Services for additional information.
- Injectable medications: Except as described under the section Covered Health Care Services, injectable medications including, but not limited to, infusion therapy, allergy serum, certain immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical *Combined Evidence of Coverage and Disclosure Form*. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Prior Authorization requirements. For additional information, refer to Section 1 of your medical *Combined Evidence of Coverage and Disclosure Form* under Covered Health Care Services.
- Inpatient Prescription Drug Products: Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this *Pharmacy Schedule of Benefits*. Please refer to Section 1 of your medical *Combined Evidence of Coverage and Disclosure Form* entitled Covered Health Care Services for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Network Pharmacy in accordance with all the terms and conditions of coverage set forth in this *Schedule of Benefits* and in the Pharmacy Supplement to the *Combined Evidence of Coverage and Disclosure Form*. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Network Physician at a Network Pharmacy, and pay the applicable Co-payment on behalf of the Member.
- Investigational or Experimental drugs: Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section 1, Covered Health Care Services and Section 6: Questions, Complaints and Appeals for appeal rights.
- New Prescription Drug Products 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. This would include new dosage forms that we determine do not meet the definition of a Covered Health Care Service.
- Non-covered medical condition: Prescription Drug Products for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary Prescription Drug Products directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- Off-label drug use. Off-label drug use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a Network licensed health care professional. (3) The drug is Medically

Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) The American Hospital Formulary Service Drug Information, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen; (i) The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics Compendium; (iii) The Thompson Micromedex DRUGDEX System, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a PDL, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.

- Over-the-Counter Drugs: Drugs available over-the-counter do not require a Prescription Order or Refill by federal or state law before being dispensed. Generally over- the-counter Drugs are excluded whether prescribed or not unless they are on UnitedHealth care's PDL 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. This exclusion does not apply to prescribed over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section *5 of the* Combined *Evidence of Coverage and Disclosure Form*. When determining covered FDA approved contraceptive methods, the Plan will consider Therapeutic Equivalent including dosage form and route of administration strength. For more information regarding coverage of certain over- the-counter drugs on the PDL, 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.
- Prescription Drug Products that are comprised of active ingredients that are available over-the-counter are not covered except when Medically Necessary. Certain prescription drug products that are Therapeutically Equivalent to over the counter drugs or supplement are not covered unless Medically Necessary and Prior Authorized. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit are not covered.
- Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government except as otherwise provided by law.
- Prescription Drug Products prescribed by a dentist or drugs when prescribed for dental treatment are not covered.
- Prescription Drug Products when prescribed solely for the purpose to shorten the duration of a common cold are not covered.
- Prescription Drug Product when packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.
- Prescription Drug Products prescribed solely to treat hair loss.
- Prior to Effective Date: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.

- Replacement of Prescription Drug Products. Lost, stolen, or destroyed Prescription Drug Products are not covered.
- Saline and irrigation solutions. Saline and irrigation solutions are not covered unless Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical *Combined Evidence of Coverage and Disclosure Form* Section 1 for additional information.
- Sexual dysfunction medication: Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- 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 1: Covered Health Care 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). 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 1: Covered Health Care Services.
- Unit/Convenience Dosage Forms: Unit doses, pre-packaged medications, individual packets etc. are not covered unless available in that form only, prior authorized and medically necessary.
- Worker's Compensation: Prescription Drug Products for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section 8: General Legal Provisions.

UnitedHealthcare Benefits Plan of California

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The 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 six times 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 and would be for your benefit. No prior notice would be given to you.

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

Step Therapy

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

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

Exceptions to Step Therapy criteria include:

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

If you change your Health Plan, we will not require you to repeat step therapy when the you are already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for 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?

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

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 Override

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

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

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

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

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

UnitedHealthcare's Mail Order Pharmacy Program

What is the Mail Order Pharmacy Program?

UnitedHealthcare offers a Mail Order Pharmacy Program through *Optum Rx*®. The Mail Order Pharmacy Program provides convenient service and savings on Maintenance Medications that you may take on a regular basis 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).

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.

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

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

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.

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

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

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

Prescription Drug Product - a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill.

A Prescription Drug Product includes a 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, glucose meters (including continuous glucose monitors), certain immunizations and anaphylaxis prevention kits. See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medication and equipment for the treatment of asthma in Section 1: Covered Health Care Services

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. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.

Tier - The tiers for Outpatient Prescription Drugs are defined as follows:

- Tier 1- Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.
- Tier 2 -Medications that provide good overall value. A mix of brand-name and generic drugs.
- Tier 3 - Consists of non-preferred Brand-name drug or drugs 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 non-preferred Brand-name drug or drugs based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier, such as biologics, drugs that the FDA or the manufacturer requires to be

distributed through a Specialty Pharmacy, or drugs that require the insured to have special training or clinical monitoring for self-administration.

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

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 or 711 (TTY).

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. 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, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy 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 Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care 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.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

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

Under Federal law, group health plans and health insurance 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 (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, 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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

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 benefit documents 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 Benefits 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 30 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 prescription drug Benefits 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 Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to 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 Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits 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 Benefits 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 prescription drug Benefits 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 Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits 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 Benefits 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.
- 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 part of the plan 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 Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. 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 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.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the 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 representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a 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 us immediately.

How Do You 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 for an appeal 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 denial of pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen 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 expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed 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 related to your claim for Benefits. 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 in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits 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 Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place 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 shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place 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 related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could 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.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies, or surgeries.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019:

We[2] 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 care 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. We have 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.
- 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 needed 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. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **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 review 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 needed 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 needed (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 needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown 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. Such laws may protect the following types of information:

  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

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

Except for uses and disclosures described and limited as stated 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 change 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 get 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 according 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. You also may get a copy of this notice on your health plan website, such as www.myuhc.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 call us at 1-866-633-2446 or 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, for 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.

[2]*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 New Jersey, Inc.; Arizona Physicians IPA, 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.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, 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.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Health Management Corporation; Rocky Mountain HealthCare Options, 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.* This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an 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.
- 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.
- 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 call us at 1-866-633-2446 or TTY 711.

[3]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; LifePrint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health LLC, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida,*

Ltd.; POMCO West, Inc.; POMCO, Inc.; 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. 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

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), if applicable, 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 get, 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), if applicable 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 due to 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 *Consolidated Omnibus Budget Reconciliation Act* (*COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

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 get 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 $156 a day (subject to adjustment based on inflation) 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 get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: Veros Software Inc. Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Veros Software Inc.

2333 N. Broadway Suite 400

Santa Ana, CA 92706

(714) 415-6133

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 33-0958012

Plan Number: 501

Plan Year: September 1 through August 30

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

Veros Software Inc.

2333 N. Broadway Suite 400

Santa Ana, CA 92706

(714) 415-6133

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare

5701 Katella Avenue

Cypress, CA 90630

866-270-5311

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally

binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.