UnitedHealthcare®

UnitedHealthcare SignatureValue® Alliance

Offered By UnitedHealthcare of California

Combined Evidence of Coverage and
Disclosure Form (HMO) for the Basic Plan

Effective January 1, 2016

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

Outpatient Prescription drug benefit is administered by CVS Caremark. Please refer to your CVS Caremark's Evidence of Coverage (EOC) booklet for additional information regarding your outpatient pharmacy benefit.

THERE IS NO VESTED RIGHT TO RECEIVE ANY PARTICULAR BENEFIT SET FORTH IN THE PLAN. PLAN BENEFITS MAY BE MODIFIED. ANY MODIFIED BENEFIT (SUCH AS THE ELIMINATION OF A PARTICULAR BENEFIT OR AN INCREASE IN THE MEMBER'S COPAYMENT) APPLIES TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF THE MODIFICATION.

Welcome to UnitedHealthcare of California

Since 1978, we have been providing health care coverage in California. This publication will help you become more familiar with your health care benefits. It will also introduce you to our health care community.

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

What is this publication?

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

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

What else should I read to understand my benefits?

UnitedHealthcare HMO products may have a specifically defined provider Network. You must receive all routine non-emergent/urgent services through your Participating Medical Group identified on your ID card. Along with reading this publication, be sure to review your *Schedule of Benefits, Provider Directory,* Member Identification card, and any benefit materials. Your *Schedule of Benefits* provides the details of your particular Health Plan, including any Co-payments that you may have to pay when using a health care service. The *Provider Directory* has detailed information about your specific network's Participating Medical Groups and other Providers, as well as the service area for this network. If you need a copy or would like assistance picking your Primary Care Physician, please call our Customer Service department. You can also find an online version of the Directory at **www.uhc.com/calpers.** Together, these documents explain your coverage.

Not all UnitedHealthcare Participating Providers may be part of the defined Network. You must select a Primary Care Physician from the assigned network to obtain the group benefits purchased by your employer.

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please do not hesitate to call our Customer Service department at 1-877-359-3714 or 711 (TTY).

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

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

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

You may correspond with UnitedHealthcare at the following address:

UnitedHealthcare of California
P.O. Box 30968
Salt Lake City, UT 84130-0968
1-877-359-3714
UnitedHealthcare's website is: **www.uhc.com/calpers**

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15/100%

HMO Schedule of Benefits

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] (2 individual maximum per family[6])	$1,500/individual and $3,000 Family
PCP Office Visits	$15 Office Visit Copayment
Specialist Office Visits[2] (Member required to obtain referral to specialist, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$15 Office Visit Copayment
Hospital Benefits	No Charge
Emergency Services (Copayment waived if admitted)	$50 Copayment
Urgently Needed Services (Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)	$15 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	No Charge
Cancer Clinical Trials[3]	Physician Services and Hospital Services copayments apply
Hospice Services (Prognosis of life expectancy of one year or less)	No Charge
Hospital Benefits[4]	No Charge
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	No Charge
Maternity Care[8]	No Charge
Mental Health Services	No Charge
Newborn Care[4]	No Charge
Physician Care	No Charge
Reconstructive Surgery	No Charge

Questions about your benefits? Call our Customer Service Department at 1-877-359-3714 or 711 (TTY).

Benefits Available While Hospitalized as an Inpatient (Continued)

Rehabilitation Care (Including physical, occupational and speech therapy)	No Charge
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	No Charge
Termination of Pregnancy (Medical/medication and surgical)	No Charge

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 No Charge No Charge
Ambulance	No Charge
Cancer Clinical Trials[3]	Physician Services and Hospital Services copayments apply
Chiropractic Care and Acupuncture (Up to 20 visits combined maximum.)	$15 Office Visit Copayment
Cochlear Implant Devices[5] (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	No Charge
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$15 Copayment
Dialysis	$15 Office Visit Copayment
Durable Medical Equipment[5] (No annual benefit maximum per calendar year.)	No Charge
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19.)	No Charge
Family Planning (Non-Preventive Care)[9]	
Vasectomy	$15 Office Visit Copayment
Depo-Provera Injection – (other than contraception)[9]	
PCP Office Visit	$15 Office Visit Copayment
Specialist Office Visit	$15 Office Visit Copayment
Depo-Provera Medication – (other than contraception)[9] (Limited to one Depo-Provera injection every 90 days.)	$35 Copayment
Termination of Pregnancy (Medical/medication and surgical)	$15 Office Visit Copayment
Hearing Aid – Standard (Hearing Aid up to a maximum of $1,000 per Member every 36 months for both ears for the hearing aid instrument and ancillary equipment.)	No Charge
Hearing Aid - Bone Anchored[7] *Limited to a single hearing aid during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.* Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.	

Benefits Available on an Outpatient Basis (Continued)

Hearing Exam[2,8] PCP Office Visit Specialist Office Visit[2]	 $15 Office Visit Copayment $15 Office Visit Copayment
Home Health Care Visits	No Charge
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Infertility Services[1]	Copayment: 50% of Allowed Charges for all Services
Infusion Therapy[5] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment.	No Charge
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) [1,5,9] (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. Please see the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	No Charge
Laboratory Services (When available through or authorized by your Participating Medical Group)	No Charge
Maternity Care, Tests and Procedures[8] PCP Office Visit Specialist Office Visit	 No Charge No Charge
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**)	 $15 Office Visit Copayment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy) PCP Office Visit Specialist Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment
Oral Surgery Services[5]	No Charge
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No Charge

Benefits Available on an Outpatient Basis (Continued)

Preventive Care Services[8,9] (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Services will include, but are not limited to, the following: ▪ Colorectal Screening ▪ Hearing Screening ▪ Human Immunodeficiency Virus (HIV) Screening ▪ Immunizations ▪ Newborn Testing ▪ Prostate Screening ▪ Vision Screening ▪ Well-Baby/Child/Adolescent Care ▪ Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.	No Charge
Physician Care	
PCP Office Visit	$15 Office Visit Copayment
Specialist Office Visit	$15 Office Visit Copayment
Prosthetics and Corrective Appliances[5]	No Charge
Radiation Therapy[5]	
Standard: (Photon beam radiation therapy)	No Charge
Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Gamma Knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	No Charge
Radiology Services[5]	
Standard:	No Charge
Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media).	No Charge
Vision Refractions	
PCP Office Visit	No Charge
Specialist Office Visit	No Charge

[1]Annual Copayment Maximum exclude Copayments for pharmacy, infertility treatment/services and infertility drugs. See your CVS Caremark Evidence of Coverage (EOC) regarding applicable outpatient pharmacy copay limits."

[2]Copayments for audiologist and podiatrist visits will be the same as for the PCP.

[3]Cancer Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[4]The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

[5]In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate. (This footnote only applies to dollar copayments.)

[6]When an individual member meets the Annual Copayment Maximum no further copayments are required for the year for that individual. When a family meets the Annual Copayment Maximum no further copayments are required for the year for that family.

[7]Bone anchored hearing aid will be subject to applicable medical/surgical categories (.e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Limited to one (1) bone anchored hearing aid during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.

[8]Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

[9]FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.

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

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

The Medical and Hospital Group Subscriber Agreement and the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. UnitedHealthcare's most recent audited financial information is also available upon request.

SECTION 1. GETTING STARTED: YOUR PRIMARY CARE PHYSICIAN

- **What is a Primary Care Physician?**
- **What is a Subscriber?**
- **What is a Participating Medical Group?**
- **Your *Provider Directory***
- **Choosing Your Primary Care Physician**
- **Continuity of Care**

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

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

Introduction

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

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

What is a Primary Care Physician?

When you become a Member of UnitedHealthcare, one of the first things you do is choose a doctor to be your Primary Care Physician. This is a doctor who is contracted with UnitedHealthcare and who is primarily responsible for the coordination of your health care services. A Primary Care Physician is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology. At times, others may participate in the coordination of your health care services, such as a Hospitalist (Please refer to **Section 2. Seeing Your Doctor** for information on Hospitalist programs).

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

All Members of UnitedHealthcare are required to have a Primary Care Physician. If you do not select one when you enroll, UnitedHealthcare will choose one for you. Except in an urgent or emergency situation, if you see another health care Provider without the approval of either your Primary Care Physician, Participating Medical Group or UnitedHealthcare, the costs for these services will not be covered.

What is the difference between a Subscriber and an enrolled Family Member?

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

enrolled Family Members. Subscribers also have special responsibilities that are noted throughout this publication. If you are a Subscriber, please pay attention to any instructions given specifically for you. For a more detailed explanation of any terms, see the **Definitions** section of this publication.

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

Choosing a Primary Care Physician

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

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

You will find a list of our participating Primary Care Physicians in the *Provider Directory*. It is also a source for other valuable information. (Note: If you are pregnant, please read the section below, "If You Are Pregnant," to learn how to choose a Primary Care Physician for your newborn.)

Physician/Patient Relations

If the relationship between you and a Plan physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan physician.

What is a Participating Medical Group?

When you select a Primary Care Physician, you are also selecting a Participating Medical Group. This is the group that's affiliated with both your doctor and UnitedHealthcare. If you need a referral to a specialist or Non-Physician Health Care Practitioner, you will generally be referred to a doctor, Non-Physician Health Care Practitioner or service within this group. Since Participating Medical Groups are independent contractors not employed by UnitedHealthcare, each has its own unique network of affiliated specialists and Providers. Only if a specialist, Non-Physician Health Care Practitioner or service is unavailable will you be referred to a health care Provider outside your medical group.

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

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

Along with listing our Participating Physicians, your *Provider Directory* has detailed information about our Participating Medical Groups and other Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Medical Groups. Every Subscriber should receive a *Provider Directory*. If you need a copy or would like assistance picking your Primary Care Physician, please call our Customer Service department. You can also find an online version of the Directory at **www.uhc.com/calpers**.

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

Choosing a Primary Care Physician for Each Enrolled Family Member

Every UnitedHealthcare Member must have a Primary Care Physician; however, the Subscriber and any enrolled Family Members do not need to choose the same doctor. Each UnitedHealthcare Member can choose his or her own Primary Care Physician, so long as the doctor is selected from UnitedHealthcare's list of Primary Care Physicians If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code. If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's service area. When you use your work ZIP Code, all

enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

If a Family Member doesn't make a selection during enrollment, UnitedHealthcare will choose the Member's Primary Care Physician. (Note: If an enrolled Family Member is pregnant, please read below to learn how to choose a Primary Care Physician for the newborn.)

Continuity of Care for New Members at the Time of Enrollment

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

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

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

1. Continuity of Care services from Non-Participating Provider must be Pre-authorized by UnitedHealthcare or the Member's assigned Participating Provider;
2. The requested treatment must be a Covered Service under this Plan;
3. The Non-Participating Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon UnitedHealthcare's Participating Providers, including locations within UnitedHealthcare's Service Area, payment methodologies and rates of payment.

Covered Services for the Continuity of Care Condition under treatment by the Non-Participating Provider will be considered complete when:

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

Continuity of Care also applies to those new UnitedHealthcare Members who are receiving Mental Health care services from a Non-Participating Mental Health Provider at the time their coverage becomes effective. Members eligible for continuity of mental health care services may continue to receive mental health services from a Non-Participating Provider for a reasonable period of time to safely transition care to a Mental Health Participating Provider. Please refer to "Inpatient Benefits, Outpatient Benefits" and "Exclusions and Limitations of Benefits" in **Section 5. Your Medical Benefits** of the UnitedHealthcare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental mental health care coverage information, if any. For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*. A Non-Participating Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the network of Providers from whom the Member is entitled to receive Covered Services.

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

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

UnitedHealthcare's Health Services department will complete a clinical review of your Continuity of Care request for the completion of Covered Services with a Non-Participating Provider and the decision will be made and communicated in a timely manner appropriate to the nature of your medical condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of UnitedHealthcare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two (2) business days of making the decision. If your request for continued care with a Non-Participating Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

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

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

If You Are Pregnant

Every Member of UnitedHealthcare needs a Primary Care Physician, including your newborn. Newborns are assigned to the mother's Participating Medical Group from birth until discharge from the Hospital. You may request to reassign your newborn to a different Primary Care Physician or Participating Medical Group following the newborn's discharge by calling UnitedHealthcare's Customer Service department. If a Primary Care Physician isn't chosen for your child, the newborn will remain with the mother's Primary Care Physician or Participating Medical Group. If you call the Customer Service department by the 15th of the current month, your newborn's transfer will be effective on the first day of the following month. If the request for transfer is received after the 15th of the current month, your newborn's transfer will be effective the first day of the second succeeding month. For example, if you call UnitedHealthcare on June 12th to request a new doctor for your newborn, the transfer will be effective on July 1st. If you call UnitedHealthcare on June 16th, the transfer will be effective August 1st. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a request to add the baby to his or her employer group/UnitedHealthcare prior to the expiration of the 30-day period to continue coverage beyond the first 30 days of life. If your newborn has not been discharged from the Hospital, is being followed by the Case Management or is receiving acute institutional care at the time of your request, a change in your newborn's Primary Care Physician or Participating Medical Group will not be effective until the first day of the second month following the newborn's discharge from the institution or termination of treatment. When UnitedHealthcare's Case Management is involved, the Case Manager is also consulted about the effective date of your requested Physician change for your newborn.

You can learn more about changing Primary Care Physicians in **Section 4. Changing Your Doctor or Medical Group**. (For more about adding a newborn to your coverage, see **Section 7. Member Eligibility**.)

Does your Group or Hospital restrict any reproductive services?

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the UnitedHealthcare Health Plan Customer Service department at 1-877-359-3714 or 711 (TTY) to ensure that you can obtain the health care services that you need.

If you have chosen a Participating Medical Group that does not provide the family planning benefits you need, and these benefits have been purchased by your Employer Group, please call our Customer Service department.

SECTION 2. SEEING THE DOCTOR

- **Scheduling Appointments**
- **Referrals to Specialists**
- **Seeing the OB/GYN**
- **Second Medical Opinions**
- **Prearranging Hospital Stays**
- **24-Hour Support and Information**

Now that you have chosen a Primary Care Physician, you have a doctor for your routine health care.

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

Seeing the Doctor – Scheduling Appointments

To visit your Primary Care Physician, simply make an appointment by calling your doctor's office. Your Primary Care Physician is your first stop for accessing care except when you need Emergency Services, or when you require Urgently Needed Services and you are outside of the area served by your Participating Medical Group, or when your Participating Medical Group is unavailable. Without an authorized referral from your Primary Care Physician or UnitedHealthcare, no Physician or other health care services will be covered except for Emergency Services and Urgently Needed Services. (There is an exception if you wish to visit an obstetrical and gynecological Physician. See below, "OB/GYN: Getting Care Without a Referral.")

When you see your Primary Care Physician or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the health care service. Your Copayments are outlined in your *Schedule of Benefits*. More detailed information can also be found in Section **6. Payment Responsibility**.

Referrals to Specialists and Non-Physician Health Care Practitioners

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

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

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

Standing Referrals to Specialists

A standing referral is a referral by your Primary Care Physician that authorizes more than one visit to a participating specialist. A standing referral may be provided if your Primary Care Physician, in consultation with you, the specialist and your Participating Medical Group's Medical Director (or a UnitedHealthcare Medical Director), determines that as part of a treatment plan you need continuing care from a specialist. You may

request a standing referral from your Primary Care Physician or UnitedHealthcare. Please Note: A standing referral and treatment plan is only allowed if approved by your Participating Medical Group or UnitedHealthcare.

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

Extended Referral for Care by a Specialist

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

You may request an extended specialty referral by asking your Primary Care Physician or UnitedHealthcare. Your Primary Care Physician must then determine if it is Medically Necessary. Your Primary Care Physician will do this in consultation with the specialist or specialty care center, as well as your Participating Medical Group's Medical Director or a UnitedHealthcare Medical Director.

If you require an extended specialty referral, the referral will be made according to a treatment plan approved by your Participating Medical Group's Medical Director or a UnitedHealthcare Medical Director. This is done in consultation with your Primary Care Physician, the specialist and you.

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

OB/GYN: Getting Care Without a Referral

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

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

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

- Call the telephone number on the front of your Health Plan ID Card and request the names and telephone numbers of the OB/GYNs affiliated with your Participating Medical Group;
- Telephone and schedule an appointment with your selected Participating OB/GYN.

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

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

Second Medical Opinions

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

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

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

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

Either the Participating Medical Group or, if applicable, a UnitedHealthcare Medical Director will approve or deny a request for a second medical opinion. The request will be approved or denied in a timely fashion appropriate to the nature of your condition. For circumstances other than an imminent or serious threat to your health, a second medical opinion request will be approved or denied within five (5) business days after the request is received by the Participating Medical Group or UnitedHealthcare.

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

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

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

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

If your request for a second medical opinion is denied, UnitedHealthcare will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section 8. Overseeing**

Your Health Care. If you obtain a second medical opinion without Preauthorization from your Participating Medical Group or UnitedHealthcare, you will be financially responsible for the cost of the opinion.

To receive a copy of the Second Medical Opinion timeline, you may call or write UnitedHealthcare's Customer Service department at:

UnitedHealthcare Customer Service Department
P.O. Box 30968
Salt Lake City, UT 84130-0968
1-877-359-3714

What is UnitedHealthcare's Case Management Program?

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

Prearranging Hospital Stays

Your Primary Care Physician or Hospitalist will prearrange any Medically Necessary Hospital or Facility care. Your Primary Care Physician or Hospitalist will prearrange any Medically Necessary Inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility. If you have been referred to a specialist and the specialist determines you need Hospitalization, your Primary Care Physician will work with the Specialist to prearrange your Hospital stay.

Your Hospital costs, including semi-private room, tests and office visits, will be covered, minus any required Copayments, as well as any deductibles. Under normal circumstances, your Primary Care Physician or Hospitalist will coordinate your admission to a local UnitedHealthcare Participating Hospital or Facility; however, if your situation requires it, you could be transported to a regional medical center.

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

Please note: If a Hospitalist program applies, a Hospitalist may direct your Inpatient Hospital or Facility care In consultation with of your Primary Care Physician.

Hospitalist Program

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

24-Hour Support and Information

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, and seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate;

- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Care or Urgent Care, and how and where to get that care);
- They can tell you what to do if you need care and a Participating Provider office is closed.

NurseLine is available to you at no cost. To use this convenient service, simply call 1-866-747-4325 or the toll-free number on the back of your Health Plan ID card.

By calling the same toll-free number, you can also listen to one of the pre-recorded messages on various health and well-being topics, with many available in Spanish.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

SECTION 3. EMERGENCY AND URGENTLY NEEDED SERVICES

- **What is an Emergency Medical Condition?**
- **What to Do When You Require Emergency Services**
- **Post-Stabilization and Follow-up Care**
- **Out-of-Area Services**
- **What to Do When You Require Urgently Needed Services**
- **What to Do if You are Abroad**

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

IMPORTANT!

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

What are Emergency Medical Services?

Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 emergency response system. It is also the medical screening, examination and evaluation by a Physician, or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition or Psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to stabilize or eliminate the Emergency Medical Condition or Psychiatric Emergency Medical Condition within the capabilities of the Facility which includes admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital for the purpose of providing care and treatment necessary to relieve or eliminate a Psychiatric Emergency Medical Condition.

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

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

- Placing the Member's health in serious jeopardy;
- Serious impairment to his or her bodily functions;
- A serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would occur:
  - There is inadequate time to effect a safe transfer to another Hospital prior to delivery; or
  - A transfer poses a threat to the health and safety of the Member or unborn child.

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

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

What to Do When You Require Emergency Services

If you believe you are experiencing an Emergency Medical Condition, call 911 or go directly to the nearest Hospital emergency room or other Facility for treatment. You do not need to obtain Preauthorization to seek

treatment for an Emergency Medical Condition that could cause you harm. Ambulance transport services provided through the 911 emergency response system are covered if you reasonably believe that your medical condition requires emergency ambulance transport services. UnitedHealthcare covers all Medically Necessary Emergency Services provided to Members in order to stabilize an Emergency Medical Condition.

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

Post-Stabilization and Follow-up Care

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

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTING PROVIDER, PLEASE CONTACT UNITEDHEALTHCARE AT 1-877-359-3714.

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

Out-of-Area Services

UnitedHealthcare arranges for the provision of Covered Services through its Participating Medical Groups and other Participating Providers. With the exception of Emergency Services, Urgently Needed Services, authorized post-stabilization care or other specific services authorized by your Participating Medical Group or UnitedHealthcare, when you are away from the geographic area served by your Participating Medical Group, you are not covered for any other medical or Hospital Services. If you do not know the area served by your Participating Medical Group, please call your Primary Care Physician or the Participating Medical Group's administrative office to inquire.

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

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

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

What to Do When You Require Urgently Needed Services

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

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

Out-of-Area Urgently Needed Services

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

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

When you are temporarily outside the geographic area served by your Participating Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group as described above in "What to Do When You Require Urgently Needed Services." The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your UnitedHealthcare Health Plan ID card. Assistance is available 24 hours a day, seven days a week. Identify yourself as a UnitedHealthcare Member and ask to speak to a Physician. If you are calling during non-business hours, and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions.

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

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

International Emergency and Urgently Needed Services

If you are out of the country and require Urgently Needed Services, you should still, if possible, call your Primary Care Physician or Participating Medical Group. Just follow the same instructions outlined above. If you are out of the country and experience an Emergency Medical Condition, either use the available emergency response

system or go directly to the nearest Hospital emergency room. Following receipt of Emergency Services, please notify your Primary Care Physician or Participating Medical Group within 24 hours, or as soon as reasonably possible, after initially receiving these services.

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

ALWAYS REMEMBER

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

Urgently Needed Services: When you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group. If you are unable to contact your Primary Care Physician or Participating Medical Group, and you receive medical or Hospital Services, you must notify UnitedHealthcare or your Primary Care Physician within 24 hours, or as soon as reasonably possible of initially receiving these services.

MEMBERS ARE NOT FINANCIALLY RESPONSIBLE FOR PAYMENT OF EMERGENCY CARE SERVICES BEYOND THE COPAYMENTS, COINSURANCE, AND DEDUCTIBLES.

SECTION 4. CHANGING YOUR DOCTOR OR MEDICAL GROUP

- **How to Change Your Primary Care Physician**
- **How to Change Your Participating Medical Group**
- **When We Change Your Physician or Medical Group**
- **When Medical Groups or Doctors Are Terminated by UnitedHealthcare**

There may come a time when you want or need to change your Primary Care Physician or Participating Medical Group. This section explains how to make this change, as well as how we continue your care.

Changing Your Primary Care Physician or Participating Medical Group

Whether you want to change doctors within your Participating Medical Group or transfer out of your Participating Medical Group entirely, you should contact our Customer Service department.

UnitedHealthcare will approve your request to change doctors within your Participating Medical Group if the Primary Care Physician you have selected is accepting new patients and meets the other criteria in **Section 1. Getting Started.**

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

If you wish to transfer out of your Participating Medical Group entirely, and you are not an Inpatient in a Hospital, a Skilled Nursing Facility or other medical institution, UnitedHealthcare will approve your request if the Primary Care Physician within the new Participating Medical Group you have selected is accepting new patients and meets the other criteria in **Section 1. Getting Started**. This includes being located within 30 miles of your Primary Residence or Primary Workplace. The effective date of transfer will be the same as referred to above when requesting a transfer within your Participating Medical Group.

Please Note: UnitedHealthcare does not advise that you change your Primary Care Physician if you are an Inpatient in a Hospital, a Skilled Nursing Facility or other medical institution or are undergoing radiation or chemotherapy, as a change may negatively impact your coordination of care.

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

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

If you change your Participating Medical Group, authorizations issued by your previous Participating Medical Group will not be accepted by your new group. Consequently, you should request a new referral from your new Primary Care Physician within your new Participating Medical Group, which may require further evaluation by your new Participating Medical Group or UnitedHealthcare.

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

If you are changing Participating Medical Groups, our Customer Service department may be able to help smooth the transition. When UnitedHealthcare's Case Management is involved, the Case Manager is also consulted

about the effective date of your Physician change request. At the time of your request, please let us know if you are currently under the care of a specialist, receiving home health services or using durable medical equipment such as a wheelchair, walker, Hospital bed or an oxygen delivery system.

When We Change Your Participating Medical Group

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

UnitedHealthcare will also notify the Member in the event that the agreement terminates between UnitedHealthcare and the Member's Participating Medical Group. If this occurs, UnitedHealthcare will provide 30 days' notice of the termination. UnitedHealthcare will also assign the Member a new Primary Care Physician. If the Member would like to select a different Primary Care Physician, he or she may do so by contacting Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new Primary Care Physician.

Please Note: Except for Emergency and Urgently Needed Services, once an effective date with your new Participating Medical Group has been established, a Member must use his or her new Primary Care Physician or Participating Medical Group to authorize all services and treatments. *Receiving services elsewhere will result in UnitedHealthcare's denial of benefit coverage.*

Continuing Care with a Terminated Provider

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

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

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

1. Continuity of Care services from a Terminated Provider must be preauthorized by UnitedHealthcare;
2. The requested treatment must be a Covered Service under this Plan;
3. The Terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to Termination, including, but not limited to, credentialing, Hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The Terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by UnitedHealthcare or Participating Medical Groups/Independent Practice Associations (PMG/IPA) for current Participating Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Terminated Provider.

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

i. The Member's Continuity of Care Condition under treatment is medically stable, and

ii. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the Terminated Participating Provider and, as applicable, the Member's receiving Participating Provider.

Continuity of Care also applies to Members who are receiving Mental Health care services from a Terminated Mental Health Provider, on the effective Termination date. Members eligible for continuity of Mental Health care services may continue to receive Mental Health services from the Terminated Mental Health Provider for a reasonable period of time to safely transition care to a Participating Mental Health Provider. Please refer to "Inpatient Benefits, Outpatient Benefits" and "Exclusions and Limitations of Benefits" in **Section 5. Your Medical Benefits** of the UnitedHealthcare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental Mental Health care coverage information, if any. For a description of coverage of Mental Health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*.

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

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

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

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

UnitedHealthcare's Health Services department will complete a clinical review of your Continuity of Care request for Completion of Covered Services with the Terminated Provider and the decision will be made and communicated in a timely manner appropriate for the nature of your medical condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of UnitedHealthcare's receipt of the completed form. You will be notified of the decision by telephone, and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two (2) business days of making the decision. If your request for continued care with a Terminated Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

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

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

In the above section "Continuity of Care with a Terminating Provider," **Termination, Terminated** or **Terminating** references any circumstance which terminates, non-renews or otherwise ends the arrangement by which the Participating Provider routinely renders Covered Services to UnitedHealthcare Members.

SECTION 5. YOUR MEDICAL BENEFITS

- **Inpatient Benefits**
- **Outpatient Benefits**
- **Exclusions and Limitations**

This section explains your medical benefits, including what is and isn't covered by UnitedHealthcare. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you should refer to your Schedule of Benefits, a copy of which is included with this document. UnitedHealthcare's Commercial HMO Benefit Interpretation Policy Manual and Medical Management Guidelines Manual are available at ***www.uhc.com/calpers****.*

I. Inpatient Benefits

THESE BENEFITS ARE PROVIDED WHEN ADMITTED OR AUTHORIZED BY EITHER THE MEMBER'S PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE. ALL SERVICES MUST BE MEDICALLY NECESSARY AS DEFINED IN THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM*. The fact that a Physician has ordered a particular service, supply, or treatment will not make it covered under the Health Plan. A service, supply, or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

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

1. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
2. **Bloodless Surgery** – Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin for Members who object to such transfusion on religious grounds, are covered only when available within the Member's Participating Medical Group/Hospital.
3. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a Member and the bone marrow or stem cell services are performed at a Designated Facility. The testing of relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. A Designated Facility center approved by UnitedHealthcare must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor-related clinical transplant services once a donor is identified.
4. **Cancer Clinical Trials** – All Routine Patient Care Costs related to an approved therapeutic clinical trial for cancer (Phases I, II, III and IV) are covered for a Member who is diagnosed with cancer and whose Participating Treating Physician recommends that the clinical trial has a meaningful potential to benefit the Member.

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

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

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the Investigational drug, item, device or service.
- Health care services, required for the clinically appropriate monitoring of the investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the Investigational drug, item, device or service, including the diagnosis or treatment of the complications.

For purposes of this benefit, Routine Patient Care Costs do not include the costs associated with the provision of any of the following, which are not covered by UnitedHealthcare:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, transportation, housing, companion expenses and other nonclinical expenses that the Member may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member's care.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under UnitedHealthcare.
- Health care services customarily provided by the research sponsor free of charge.

An approved clinical trial for cancer is one where the treatment either involves a drug that is exempt under federal regulations from a new drug application or is approved by one of the following:

- One of the National Institutes of Health;
- The U.S. Food and Drug Administration, in the form of an Investigational new drug application;
- The United States Department of Defense;
- The United States Department of Veterans Affairs.

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

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

UnitedHealthcare is required to pay for the services covered under this benefit at the rate agreed upon by UnitedHealthcare and a Participating Provider, minus any applicable Copayment,

Coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, the Member will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayment, Coinsurance or deductibles.

Any additional expenses the Member may have to pay beyond UnitedHealthcare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's annual Copayment maximum.

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

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

   Inpatient Hospice services are provided in an appropriately licensed Hospice Facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is necessary to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

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

7. **Inpatient Hospital Mental Health Services** – Medically Necessary Inpatient Hospital Services to treat Severe Mental Illness for adults and children and Serious Emotional Disturbances of a Child are covered, that are authorized by the Member's Medical Group or UnitedHealthcare. (See your Supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage.) Refer to the *Schedule of Benefits* for additional coverage of Mental Health Services, if any.

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

9. **Inpatient Rehabilitation Care** – Rehabilitation Services that must be provided in Inpatient rehabilitation Facility are covered. Inpatient rehabilitation consists of the combined and coordinated use of medical, physical, occupational and speech therapy when Medically Necessary and provided by a Participating

Provider who is a registered physical, speech or occupational therapist, or a healthcare professional under the direct supervision of a licensed physical therapist acting within the scope of his or her license under California law. Medically Necessary treatment of an illness, including Severe Mental Illness and Serious Emotional Disturbances of a Child or injury are covered. (For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*.) This benefit does not include Substance-Related and Addictive Disorder rehabilitation.

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

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

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

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

12. **Bariatric Surgery** – UnitedHealthcare covers hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

    - You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success,
    - A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary.

    For covered Services related to bariatric surgical procedures that you receive, you will pay the Copayments and Coinsurance you would pay if the Services were not related to a bariatric surgical procedure.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home.

We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group

13. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision and special care nursery. A newborn Copayment applies in addition to the Copayment for maternity care, unless the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or within 96 hours of the baby's cesarean delivery. Circumcision is covered for male newborns prior to Hospital discharge. See "Circumcision" under "Outpatient Benefits" for an explanation of coverage after Hospital discharge.
14. **Organ Transplant and Transplant Services** – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a Designated Facility. Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency is the same for both facilities.

    Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, UnitedHealthcare will only cover costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the Facility where the transplant is performed. The Member will be responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second Facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "Designated Facility.")
15. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include a cleft palate, cleft lip, or other craniofacial anomalies associated with a cleft palate. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or UnitedHealthcare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.

16. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Care and Skilled Rehabilitation Care are covered. The Member's Participating Medical Group or UnitedHealthcare will determine where the Skilled Nursing Care and Skilled Rehabilitation Care will be provided. Refer to your *Schedule of Benefits* for the number of days covered under your Health Plan. Subacute and Transitional Care are levels of care provided by a Skilled Nursing Facility to a Member who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Facility care than is provided to the majority of the patients in a Skilled Nursing Facility.

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

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

    Outpatient drugs and prescription medications may be available as a supplemental benefit. Please refer to "Drugs and Prescription Medication" (Outpatient) listed in "Other Exclusions and Limitations."

17. **Transgender Surgery** – Inpatient Transgender surgery requires prior authorization from UnitedHealthcare. UnitedHealthcare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

    Travel expense reimbursement is limited to reasonable expenses for transportation, meals, and lodging for the Member to obtain authorized surgical consultation, transgender reassignment surgical procedure(s), and follow-up care. The transportation and lodging arrangements must be arranged by or approved in advance by UnitedHealthcare. Reimbursement excludes coverage for alcohol and tobacco. Food and lodging expenses are not covered for any day a Member is not receiving authorized transgender reassignment services.

18. **Termination of Pregnancy** – Refer to the *Schedule of Benefits* for the terms of coverage.

II. Outpatient Benefits

The following benefits are available on an Outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Participating Medical Group or UnitedHealthcare. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form.* The fact that a Physician has ordered a particular service, supply, or treatment will not make it covered under the Health Plan. A service, supply, or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

1. **Allergy Serum** – Allergy serum, as well as needles, syringes and other supplies for the administration of the serum are covered for the treatment of allergies. Allergy serum, needles and syringes must be obtained through a UnitedHealthcare Participating Physician.

2. **Allergy Testing Treatment** – Services and supplies are covered, including provocative antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy and serum are covered according to an established treatment plan.

3. **Ambulance** – The use of an ambulance (land or air) is covered without Preauthorization, when the Member, as a Prudent Layperson, reasonably believes there is an emergency medical or psychiatric condition that requires ambulance transport to access Emergency Services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-

Emergency Service is covered only when specifically authorized by the Member's Participating Medical Group or UnitedHealthcare.

4. **Attention Deficit/Hyperactivity Disorder** – The medical management of Attention Deficit/ Hyperactivity Disorder (ADHD) is covered including the diagnostic evaluation and laboratory monitoring of prescribed drugs. Coverage for Outpatient prescribed drugs is only available if the Subscriber's Employer Group has purchased the supplemental Outpatient Prescription Drug Benefit. This medical benefit does not include family counseling; please refer to Behavioral Health supplemental benefit for terms and conditions of coverage. For additional information regarding Covered Mental Health Services please refer to the "Mental Health Services" benefit description in this section.
5. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
6. **Bloodless Surgery** – Please refer to the benefit described above under "Inpatient Benefits" for "Bloodless Surgery." Outpatient services Copayments and/or deductibles apply for any services received on an Outpatient basis.
7. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is covered only when the Member has either of the following:

   a. Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid, or

   b. Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

   Covered Services are available for a bone-anchored hearing aid that is purchased as a result of a written recommendation by a Participating Physician.

   Note: Bone-anchored hearing aid will **not** be subject to the non-implantable hearing aid limit. There will not be a dollar maximum associated with this benefit. Bone-anchored hearing aid will be subject to applicable medical/surgical categories (e.g., inpatient hospital, physician fees) only for Members who meet the medical criteria specified above. Limited to one (1) bone-anchored hearing aid during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for the implanted components of a bone-anchored hearing aid are not covered, except for malfunctions.

   Replacement of external hearing aid components for bone-anchored hearing aids is covered under the Durable Medical Equipment benefit and is subject to the Durable Medical Equipment limitations. External components for bone-anchored hearing aids are either body-worn or worn behind the ear. Examples of external components include an external abutment and a sound processor. Replacement of external hearing aid components is only covered due to malfunction and when the condition of the device or part requires repairs that exceed the cost of replacement. Deluxe model and upgrades that are not Medically Necessary are not covered.

   Please refer to the "Hearing Aid and Hearing Device" benefit description in this section for non-implantable hearing aid; the *Schedule of Benefits* for applicable Copayments and to the "Bone-Anchored Hearing Aid" exclusion listed in "Other Exclusions and Limitations."
8. **Cancer Clinical Trials** – Please refer to the benefit described above under Inpatient "Cancer Clinical Trials." Outpatient services Copayments and/or deductibles apply for any Cancer Clinical Trials services received on an Outpatient basis according to the Copayments for that specific Outpatient service. UnitedHealthcare is required to pay for the services covered under this benefit at the rate agreed upon by UnitedHealthcare and a Participating Provider, minus any applicable Copayment, Coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with

Participating Providers, the Member will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayment, Coinsurance or deductibles.

Any additional expenses the Member may have to pay beyond UnitedHealthcare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's Annual Copayment Maximum.

9. **Circumcision** – Circumcision is covered for male newborns prior to Hospital discharge. Circumcision is covered after Hospital discharge only when:

   - Circumcision was delayed by the Participating Provider during initial Hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the 28-day neonatal period, or
   - Circumcision was determined to be medically inappropriate during initial Hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.). The circumcision is covered when the Participating Provider determines it is medically safe and the circumcision is performed within 90 days from that determination.

   Circumcision other than noted under the Outpatient Circumcision benefit will be reviewed for Medical Necessity by the Participating Medical Group or UnitedHealthcare Medical Director or designee.

10. **Cochlear Implant Device** – An implantable cochlear device for bilateral, profoundly hearing-impaired individuals or prelingual individuals who are not benefited from conventional amplification (hearing aids) is covered. Please also refer to "Cochlear Implant Medical and Surgical Services."

11. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing impaired or prelingual individuals who are not benefited from conventional amplification (hearing aids) is covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Participating Provider. (For an explanation of speech therapy benefits, please refer to "Outpatient Medical Rehabilitation Therapy.")

12. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services: Dental Treatment Anesthesia."

13. **Diabetic Management and Treatment** – Coverage includes Outpatient self-management training, education and medical nutrition therapy services. The diabetes Outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Participating Provider.

14. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Member, including but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; podiatry services; and devices to prevent or treat diabetes-related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered.

    Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses. The Member's Participating Provider will prescribe insulin syringes, lancets, glucose test strips and ketone urine test strips to be filled at a CVS Caremark contracted pharmacy. .

15. **Dialysis** – Acute and chronic hemodialysis and peritoneal dialysis services and supplies are covered. Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's Participating Medical Group or UnitedHealthcare and provided within the Member's Participating Medical Group. The fact that

the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

16. **Durable Medical Equipment (Rental, Purchase or Repair)** – Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member, and the equipment is primarily for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, Hospital beds, standard oxygen-delivery systems and equipment for the treatment of asthma (nebulizers, masks, tubing and peak flow meters, the equipment and supplies must be prescribed by and are limited to the amount requested by the Participating Physician). Outpatient drugs, prescription medications and inhaler spacers for the treatment of asthma are available through the Outpatient Prescription Drug Program administered by CVS Caremark. Please refer to the Pharmacy *Schedule of Benefits*, "Medication Covered by Your Benefit" under "Miscellaneous Prescription Drug Coverage" for coverage.

    Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Participating Medical Group or UnitedHealthcare has the option to repair or replace Durable Medical Equipment items. Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to accommodate the Member's condition.

    For a detailed listing of covered Durable Medical Equipment, please contact the UnitedHealthcare Customer Service department at 1-877-359-3714.

    Please refer to "Bone-Anchored Hearing Aid" in the "Outpatient Benefits" section and in the "Other Exclusions and Limitations" section for a description of coverage for external hearing aid components subject to the Durable Medical Equipment benefit and limitations.

17. **Family Planning** – With respect to women, Covered Services include Food and Drug Administration (FDA) approved contraceptive methods prescribed by a Participating Provider, sterilization procedures, and contraceptive education and counseling in accordance with the Health Resources and Services Administration-supported guidelines. Refer to the *Schedule of Benefits* for the specific terms of coverage under your Health Plan.

18. **Footwear** – Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Participating Medical Group or UnitedHealthcare.

19. **Health Education Services** – Includes wellness programs such as a stop smoking program available to enrolled Members. UnitedHealthcare also makes health and wellness information available to Members. For more information about the stop smoking program or any other wellness program, call the UnitedHealthcare Customer Service department at 1-877-359-3714, or visit the UnitedHealthcare website.

    Smoking Cessation

    Members who participate and complete a smoking cessation class or program will be reimbursed up to $100 per class or program per calendar year. Members may contact their medical group for information

about these classes and programs. If you have a question about the smoking cessation benefit, you should call UnitedHealthcare at 1- 877-359-3714 or 711 (TTY)

The Member's Participating Medical Group may offer additional community health programs. These programs are independent of health improvement programs offered by UnitedHealthcare and are not covered. Fees charged will not apply to the Member's Copayment maximum.

20. **Hearing Aids and Hearing Devices** – Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) are covered. Hearing aids are electronic amplifying devices designated to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

    Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Participating Physician. Covered Services are provided for the hearing aid and for charges for associated fitting and testing.

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

    Please refer to the *Schedule of Benefits* for any applicable Copayments, and Deductible Amounts, maximum and benefit limitations in the "Hearing Aid and Hearing Device" listed in "Other Exclusions and Limitations." For implantable hearing aid, refer to "Bone-Anchored Hearing Aid" in this section.

21. **Home Health Care Visits** – A Member is eligible to receive Home Health Care Visits if the Member: (i) is confined to the home (home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities); (ii) needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and (iii) the Home Health Care Visits are provided under a plan of care established and periodically reviewed and ordered by a UnitedHealthcare Participating Provider. "Skilled Nursing Services" means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse.

    If a Member is eligible for Home Health Care Visits in accordance with the authorized treatment plan, the following Medically Necessary Home Health Care Visits may be included but are not limited to:

    a. Skilled nursing visits;

    b. Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the Member's illness or injury;

    c. Physical, occupational or speech therapy that is provided on a per visit basis;

    d. Medical supplies, durable medical equipment;

    e. Infusion therapy medications and supplies and laboratory services as prescribed by a Participating Provider to the extent such services would be covered by UnitedHealthcare had the Member remained in the Hospital, rehabilitation or Skilled Nursing Facility.

    If the Member's Participating Medical Group determines that Skilled Nursing Service needs are more extensive than the services described in this benefit, the Member will be transferred to a Skilled Nursing Facility to obtain services. UnitedHealthcare, in consultation with the Member's Participating Medical Group, will determine the appropriate setting for delivery of the Member's Skilled Nursing Services.

    Please refer to the *Schedule of Benefits* for any applicable Copayments and benefit limitations.

22. **Hospice Services** – Hospice services are covered for Members with a Terminal Illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Member's

interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver.

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

Covered Hospice services are available in the home on a 24-hour basis when Medically Necessary, during periods of crisis, when a Member requires continuous care to achieve palliation or management of acute medical symptoms. Inpatient Hospice services are provided in an appropriately licensed Hospice Facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is necessary to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

23. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any.

24. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** –

    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route (includes chemotherapy). Infusion therapy is covered when furnished as part of a treatment plan authorized by the Member's Primary Care Physician, Participating Medical Group or UnitedHealthcare. The infusions must be administered in the Member's home, Participating Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living Facility that is not a Hospital or institution primarily engaged in providing Skilled Nursing Services or Rehabilitation Services.

    - **Outpatient Injectable Medications** – Outpatient injectable medications (except insulin) include those drugs or preparations which are not usually self-administered and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as a customary component of a Physician's office visit and when not otherwise limited or excluded (e.g., insulin, certain immunizations, infertility drugs, birth control or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Participating Provider, the Member's Participating Medical Group or UnitedHealthcare Designated Pharmacy and may require preauthorization by UnitedHealthcare. Please refer to "Preventive Care Services" in the outpatient benefits section for a description of immunizations covered as preventive care.

    - **Self-Injectable Medications** – Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by the Subcutaneous route regardless of the frequency of administration, or by the Intramuscular route at a frequency of one or more times per week. Self-injectable medications (except insulin) are covered when prescribed by a Participating Provider, as authorized by the Member's Participating Medical Group or by UnitedHealthcare. Self-injectable medications must be obtained through a Participating Provider, through the Member's Participating Medical Group or UnitedHealthcare-designated pharmacy/specialty injectable vendor, and may require preauthorization by UnitedHealthcare. A separate Copayment applies to all self-injectable medications for a 30-day supply (or for the prescribed course of treatment if shorter), whether self-administered or injected in the Physician's office, and is applied in addition to any office visit Copayment.

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

26. **Maternity Care, Tests and Procedures** – Physician visits, laboratory services (including the California Department of Health Services' expanded alpha fetoprotein (AFP) program), and radiology services are covered for prenatal and postpartum maternity care. Nurse midwife services are covered when available within and authorized by the Member's Participating Medical Group.

    Genetic testing and counseling are covered when authorized by the Member's Participating Medical Group as part of an amniocentesis or chorionic villus sampling procedure.

    When certain laboratory services are performed as prenatal preventive screening, as defined by the United Services Preventive Services Task Force (USPSTF) with an "A" or "B" recommendation and the Department of Health and Human Services (HHS). Covered Services are provided under "Preventive Care Services" in the outpatient benefits section.

27. **Medical Supplies and Materials** – Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the Participating Provider's office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Participating Provider. Examples of items commonly furnished in the Participating Provider's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts.

28. **Mental Health Services** – Only services to treat Severe Mental Illness for adults and children and Serious Emotional Disturbances of a Child are covered, which include Medically Necessary behavioral health treatment administered by qualified autism service providers who are either licensed providers under the Business and Professions Code or other professionals as authorized under California law or persons, entities or groups certified by a national entity. (See your Supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage.) Refer to the *Schedule of Benefits* for additional coverage of Mental Health Services, if any.

29. **OB/GYN Physician Care** – See "Physician OB/GYN Care."

30. **Oral Surgery and Dental Services** – Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable. Other covered oral surgery and dental services include:

    - Oral surgery or dental services, rendered by a Physician or dental professional for treatment of primary medical conditions. Examples include, but are not limited to:
        - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ);
        - Biopsy of gums or soft palate;
        - Oral or dental examinations performed on an Inpatient or Outpatient basis as part of a comprehensive workup prior to transplantation surgery;
        - Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
        - Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes);
        - Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
        - Reconstructive surgery due to congenital defect such as cleft lip and cleft palate. Refer to "Reconstructive Surgery" procedure.

- Ridge augmentation or alveoplasty are covered when determined to be Medically Necessary based on state cosmetic reconstructive surgery law and jawbone surgery law;
- Setting of the jaw or facial bones;
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;
- Treatment of maxillofacial cysts, including extraction and biopsy.

Dental Services beyond emergency treatment to stabilize an acute injury, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures are not covered. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, dental services include those for crowns, root canals, replacement of teeth, complete dentures, gold inlays, fillings, and other dental services specific to the replacement of teeth or structures directly supporting the teeth and other dental services specific to the treatment of the teeth are not covered except for services covered by UnitedHealthcare under this Outpatient benefit, "Oral Surgery and Dental Services."

31. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – 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.

    The Member's dentist must obtain Preauthorization from the Member's Participating Medical Group or UnitedHealthcare before the dental procedure is provided.

    Dental anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered by UnitedHealthcare under the Outpatient benefit, "Oral Surgery and Dental Services."

32. **Outpatient Medical Rehabilitation Therapy** – Services are covered when Medically Necessary and provided by a Participating Provider who is a registered physical, speech or occupational therapist, or a health care professional under the direct supervision of a licensed physical therapist acting within the scope of his or her license or otherwise authorized under California law. Medically Necessary treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are covered. (For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*.).

33. **Outpatient Prescription Drug Benefits –** The Outpatient Prescription Drug Program is administered by CVS Caremark. Please refer to your CVS Caremark Prescription Drug Program Evidence of Coverage booklet for additional details. Please contact CVS Caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

34. **Outpatient Services** – Medically Necessary services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital are covered. Examples include, but are not limited to: endoscopies, hyperbaric oxygen and wound care.

35. **Outpatient Surgery** – Short-stay, same-day or other similar Outpatient surgery facilities and professional services are covered when provided as a substitute for Inpatient care.

36. **Preventive Care Services** – Preventive Care Services means Covered Services provided on an outpatient basis at a Participating Physician's office or a Participating Hospital that encompasses medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to be associated with beneficial health outcomes and include the following as required under applicable law:

    - Evidence-based items or services that have in effect a rating of “A” or “B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
    - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.
    - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including well-woman visits (including routine prenatal obstetrical office visits); gestational diabetes screening; human papillomavirus (HPV) DNA testing for women 30 years and older every 3 years; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus (HIV); FDA-approved contraceptive methods and counseling; breastfeeding support and counseling; breast pump purchase of personal pump and supplies; and screening and counseling for interpersonal and domestic violence.

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

    - **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member’s Primary Care Physician. Mammography for screening or diagnostic purposes is covered as authorized by the Member’s participating nurse practitioner, participating nurse midwife or Participating 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 participating health professional is covered to determine the need for hearing correction. Hearing screening tests for Members are covered in accordance 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 evaluations 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:
  - Tobacco cessation counseling sessions of at least (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 regimen 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 smoking cessation drugs (both over-the-counter and prescription).
  - Smoking cessation medications (both over-the-counter and prescription) covered at zero cost share when prescribed and prior authorized. In addition you must participate in tobacco cessation counseling sessions as described above. Please contact Customer Service for more information.
- **Vision Screening** – Annual routine eye health assessment and screening by a Participating Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.
- **Well-Baby/Child/Adolescent Care** – Preventive health services are covered (including immunizations) when provided by the child's Participating Medical Group.
- **Well-Woman Care** – Medically Necessary obstetrical and gynecological services, including a Pap smear (cytology) and routine prenatal obstetrical office visits are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with Member's Participating Medical Group.

37. **Phenylketonuria (PKU) Testing and Treatment** – Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Participating Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by UnitedHealthcare, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein, but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than one gram of protein per serving.
38. **Physician Care (Primary Care Physician and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's Primary Care Physician are covered. Services of a specialist are covered upon referral by Member's Participating Medical Group or UnitedHealthcare. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
39. **Physician OB/GYN Care** – The Member may obtain obstetrical and gynecological Physician services directly from an OB/GYN, Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with the Member's Participating Medical Group.
40. **Prosthetics and Corrective Appliances/Orthotics (Non-Foot Orthotics)** – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the

Member's Participating Medical Group or UnitedHealthcare. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, nondental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

Custom-made or custom-fitted Corrective Appliances/non-foot orthotics are covered when Medically Necessary as determined by the Member's Participating Medical Group or UnitedHealthcare. Corrective Appliances/non-foot orthotics are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual member.

- Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered.
- Deluxe upgrades that are not Medically Necessary are not covered.
- Replacements, repairs and adjustments to both corrective appliances/non-foot orthotics and prosthetics are covered when Medically Necessary. Repair or replacement must be authorized by the Member's Participating Medical Group or UnitedHealthcare.
- An artificial larynx or electronic speech aid is covered post-laryngectomy or for a Member with permanently inoperative larynx condition

Refer to "Footwear" in "Outpatient Benefits" and "Foot Orthotics/Footwear" in "Other Exclusions and Limitations."

For a detailed listing of covered durable medical equipment, and prosthetic and corrective appliances, please contact the UnitedHealthcare Customer Service department at 1-877-359-3714.

41. **Radiation Therapy (Standard and Complex) –**
    - Standard photon beam radiation therapy is covered.
    - Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation and IMRT. (Gamma knife procedures and stereotactic radiosurgery procedures are covered as Outpatient surgeries for the purpose of determining Copayments. (Please refer to your *Schedule of Benefits* for applicable Copayment, if any.)
42. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or UnitedHealthcare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.
43. **Refractions** – Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if the Member's health plan includes a supplemental vision benefit.) Coverage under this benefit also includes one (1) initial pair of eyeglasses when prescribed following cataract surgery with an intraocular lens implant. Eyeglasses must be obtained through Participating Medical Group.
44. **Standard X-rays** – Standard X-rays are covered for the diagnosis of an illness or injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas and oral cholecystograms),

mammograms, obstetrical ultrasounds and bone mineral density studies (including ultrasound and DEXA scans). See "Specialized Scanning and Imaging Procedures" in "Outpatient Benefits" for coverage and examples of specialized scanning and imaging procedures.

45. **Specialized Scanning and Imaging Procedures** – Specialized Scanning and Imaging Procedures are covered for the diagnosis and ongoing medical management of an illness or injury. Specialized procedures are defined to include those which, unless specifically classified as standard X-rays (see "Standard X-rays," item # 43, in "Outpatient Benefits"), are digitally processed or computer-generated or which require contrast administered by injection or infusion. Examples of Specialized Scanning and Imaging Procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET. SPECT, MRI, MRA, EKG, EEG, EMG, and nuclear scans, angiograms (includes heart catheterization), arthrograms, myelograms, and non-obstetrical ultrasounds.

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

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

    UnitedHealthcare will not require the use of Telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician health care provider pursuant to his or her arrangement with UnitedHealthcare.

47. **Transgender Services** – Outpatient Services including outpatient surgery services for transgender surgery, services related to the surgery, outpatient office visit, and related services, requires prior authorization by UnitedHealthcare. UnitedHealthcare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. (Hormone therapy is covered through the Outpatient Prescription Drug Program administered by CVS Caremark or medical benefits and psychological and psychiatric therapy is covered under mental health benefits.)

III. Exclusions and Limitations of Benefits

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage or limited under this Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*. (Note: Additional exclusions and limitations may be included with the explanation of your benefits in the additional materials.)

General Exclusions

1. Services that are rendered without authorization from the Member's Participating Medical Group or UnitedHealthcare (except for Emergency Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form*, and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, Family Practice Physician or surgeon designated by the Member's Participating Medical Group as providing OB/GYN services), are not covered except for Emergency Services and out-of-area Urgently Needed Services.

2. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member's Participating Medical Group, without authorization from UnitedHealthcare or the Participating Medical Group, are not covered except for Emergency Services and out-of-area Urgently Needed Services.

3. Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. UnitedHealthcare does not cover the cost of services provided in preparation for a non-Covered Service where such services would not otherwise be Medically Necessary. Additionally, UnitedHealthcare does not cover the cost of routine follow-up care for non-Covered Services (as recognized by the organized medical community in the State of California). UnitedHealthcare will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.
5. Services performed by immediate relatives or members of your household are not covered.
6. Services obtained outside the Service Area are not covered except for Emergency Services or Urgently Needed Services.

Other Exclusions and Limitations

1. **Acupressure** –Acupressure is not covered.
2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
3. **Ambulance** – Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation would be more appropriate. Wheelchair transportation services (e.g., a private vehicle or taxi fare are also not covered.

   Please refer to "Ambulance" in the "Outpatient Benefits" section and "Organ Transplants" in the "Other Exclusions and Limitations" section.
4. **Artificial Hearts** – Artificial hearts are considered Experimental and are, therefore, not covered. A Member may be entitled to an expedited external, independent review of UnitedHealthcare's coverage determination regarding Experimental or Investigational therapies as described in **Section 8**.
5. **Bariatric Surgery –** UnitedHealthcare covers hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

   - You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
   - A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

   For covered Services related to bariatric surgical procedures that you receive, you will pay the **Copayments and Coinsurance you would pay if the Services were not related to a bariatric surgical procedure**.

   If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

   - Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group

- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group

6. **Behavior Modification** – Behavior modification is not covered. Behavior modification is used in behavioral programs to denote methods for conditioning behavior by pairing a behavior with a reinforcement to reward the person if they implement a desired behavior or if they stop undesired behavior. Behavior modification can also involve incurring an unpleasant consequence for undesired behavior. Behavior modification may involve setting goals for desired behavior; goals are specific, measurable, attainable, and age- and developmental stage-appropriate. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply or exclude medically necessary behavior health therapy services for treatment of pervasive developmental disorders (PDD) or Autism.
7. **Biofeedback** – Biofeedback services are not covered except when Medically Necessary for the treatment of urinary incontinence, fecal incontinence or constipation for Member with organic neuromuscular impairment and part of an authorized treatment plan.
8. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Medical Group.
9. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is not covered except when either of the following applies:
   a. For Members with craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid, or
   b. For Members with hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

   Limited to one bone-anchored hearing aid per Member who meets the above coverage criteria during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for the implanted components of a bone-anchored hearing aid for a Member who meets the above coverage criteria are not covered, other than for malfunctions. Replacement of external hearing aid components for bone-anchored hearing aids is covered under the Durable Medical Equipment benefit and is subject to the Durable Medical Equipment limitations. External components for bone-anchored hearing aids are either body-worn or worn behind the ear. Examples of external components include an external abutment and a sound processor. Replacement of external hearing aid components is only covered due to malfunction and when the condition of the device or part requires repairs that exceed the cost of replacement. Deluxe model and upgrades that are not Medically Necessary are not covered.
10. **Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." The testing for compatible unrelated donors, and costs for computerized national and international searches for

unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. Unrelated donor searches must be performed at a UnitedHealthcare-approved transplant center. (See “Designated Facility” in **Definitions**.)

11. **Breast Pumps** – Covered Services are limited to one breast pump in conjunction with childbirth. The breast pump must be obtained from a Participating Provider as determined by the Member’s Participating Medical Group or by UnitedHealthcare. If more than one breast pump can meet the Member’s needs, Covered Services are available only for the most cost effective pump that meets the Member’s needs. The Member’s Participating Medical Group or UnitedHealthcare will determine the following:
    - Which pump is the most cost effective.
    - Timing of an acquisition.
12. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered. For a detailed listing of covered durable medical equipment, and prosthetic and corrective appliances, please contact the UnitedHealthcare Customer Service department at 1-877-359-3714.
13. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine is not covered unless purchased by the Subscriber’s Employer Group as a supplemental benefit. Religious non-medical health care is not covered. (See the definition for “Complementary and Alternative Medicine.”)
14. **Cosmetic Services and Surgery** –Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member’s dissatisfaction with his or her appearance.

    No benefits are provided for:

    - Liposuction to reshape waist, hips, thighs and buttocks;
    - Electrolysis and laser hair removal, except when required as part of covered transgender genital reconstruction surgery;
    - Drugs for hair loss or growth;
    - Voice therapy or voice modification surgery except for Medically Necessary services related to or as a result of laryngectomy or other Medically Necessary services related to the larynx;
    - Sperm or gamete procurement for future infertility or storage of sperm, gametes, or embryos; and
    - Intersex surgery (transsexual operations) except as specifically provided under the “Limited Transgender Benefit" or treatment of any resulting complications, unless that treatment is determined to be medically necessary.
    - Members who have not completed 12 months of continuous hormone therapy for those without contraindications.
15. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed hospice Facility incident to a Member’s terminal illness as described in the explanation of Hospice Services in the “Your Medical Benefits” section of this *Combined Evidence of Coverage and Disclosure Form*. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. This exclusion does not apply to authorized Medically Necessary covered skilled services provided to a Member residing in a Custodial Care facility.

16. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the Outpatient benefit captioned, "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for dental care may be available if purchased by the Subscriber's employer as a separate benefit. If your Health Plan includes a dental care separate benefit, a brochure describing it will be enclosed with these materials.)
17. **Dental Treatment Anesthesia** – Dental treatment anesthesia provided or administered in a dentist's office is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered by UnitedHealthcare under the Outpatient benefit, "Oral Surgery and Dental Services."
18. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Participating Medical Group. The fact that the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.
19. **Disabilities Connected to Military Services** – Treatment in a government Facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency, and to which Member has reasonable access, is not covered.
20. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit through the Outpatient Drug Program administered by CVS Caremark. Infusion drugs, infusion therapy, and prescribed contraceptive drugs required by Federal law are not considered Outpatient drugs for the purposes of this exclusion. Refer to "Injectable Drugs", "Family Planning" and "Infusion Therapy" in the outpatient benefits section for benefit coverage. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.
21. **Durable Medical Equipment** – Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to accommodate the Member's physical condition. For a detailed listing of covered durable medical equipment please contact the UnitedHealthcare Customer Service department at 1-877-359-3714.

    Please refer to "Bone-Anchored Hearing Aid" in the "Outpatient Benefits" section and in the "Other Exclusions and Limitations" section for a description of coverage for external hearing aid components subject to the Durable Medical Equipment benefit and limitations.
22. **Educational Services for Developmental Delays and Learning Disabilities** – Educational services for Developmental Delays and Learning Disabilities are not health care services and are not covered. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade. The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress: academic coaching, teaching members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the

purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

UnitedHealthcare refers to *American Academy of Pediatrics, Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services.

For example, we do not cover:

- Items and services to increase academic knowledge or skills;
- Special education (teaching to meet the educational needs of a person with Intellectual Disability, Learning Disability, or Developmental delay. (A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to Covered Services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified health care professional, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law;
- Teaching and support services to increase academic performance;
- Academic coaching or tutoring for skills such as grammar, math, and time management;
- Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Participating Healthcare Professional acting within the scope of his or her license under California law that is intended to address speech impediments law;
- Teaching you how to read, whether or not you have dyslexia;
- Educational testing;
- Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply or exclude Medically Necessary behavior health therapy services for treatment of pervasive developmental disorders (PDD) or Autism.

23. **Elective Enhancements** – Procedures, technologies, services, drugs, devices, items and supplies for elective, non-Medically Necessary improvements, alterations, enhancements or augmentation of appearance, skills, performance capability, physical or mental attributes, or competencies are not covered. This exclusion includes, but is not limited to, elective improvements, alterations, enhancements, augmentation, or genetic manipulation related to hair growth, aging, athletic performance, intelligence, height, weight or cosmetic appearance. Please refer to "Reconstructive Surgery" for a description of Reconstructive Surgery services covered by your Health Plan.
24. **Enteral Feeding** – Enteral Feedings (food and formula) and the accessories and supplies are not covered. Formulas and special food products for phenylketonuria (PKU) are covered as described under the outpatient benefit captioned "Phenylketonuria (PKU) Testing and Treatment." Pumps and tubing are covered under the "Durable Medical Equipment" outpatient benefit.
25. **Exercise Equipment and Services** – Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.

26. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or investigational procedures, items and treatments are not covered unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a UnitedHealthcare Medical Director, or his or her designee. For the purposes of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

    - It cannot lawfully be marketed without the approval of the U.S. Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum-tolerated dose or effectiveness in comparison to conventional treatments.
    - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
    - The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
    - It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

    The sources of information to be relied upon by UnitedHealthcare in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this plan, include, but are not limited to, the following:

    - The Member's medical records;
    - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
    - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
    - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
    - Expert medical opinion;
    - Opinions of other agencies or review organizations, e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman;
    - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Health Care Policy and Research (AHCPR).

    A Member with a life-threatening or seriously debilitating condition may be entitled to an expedited external, independent review of UnitedHealthcare's coverage determination regarding Experimental or

Investigational therapies as described in **Section 8. Overseeing Your Health Care**, "Experimental or Investigational Treatment Decisions."

27. **Eyewear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for the treatment of keratoconus, aphakia, as a corneal bandage, and one pair after each cataract extraction). Surgical and laser procedures to correct or improve refractive error are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.) Routine screenings for glaucoma are limited to Members who meet the medical criteria.
28. **Family Planning** – Family planning benefits, other than those specifically listed in the "Family Planning" outpatient benefit and in the *Schedule of Benefits* that accompanies this document, are not covered. All non-prescription (over-the-counter) drugs, supplies and devices are not covered.
29. **Follow-up Care: Emergency Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Services or Urgently Needed Services, including, but not limited to, treatments, procedures, X-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Care are not covered without the Participating Medical Group's or UnitedHealthcare's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.
30. **Foot Care** – Except as Medically Necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.
31. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. (Coverage for specialized footwear for foot disfigurement may be available if the Subscriber's employer purchased a footwear supplemental benefit. If your Health Plan includes a footwear supplemental benefit, a brochure describing it will be enclosed with these materials.) Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Participating Medical Group or UnitedHealthcare.
32. **Genetic Testing, Treatment or Counseling** – Non-Medically Necessary screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions/treatment while a newborn, a child or adolescence. Members who have no clinical evidence or family history of a genetic abnormality.

    Refer to "Preventive Care Services" and "Maternity Care, Tests, Procedures, and Genetic Testing" in the "Outpatient Benefits" section for coverage of amniocentesis and chorionic villus sampling.
33. **Government Services and Treatment** – Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law or as noted below:
    - **Services While Confined or Incarcerated** – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, UnitedHealthcare will reimburse Members their out-of-pocket expenses for services received while confined/incarcerated, or, if a juvenile, while detained in any Facility, if the services were provided or authorized by your Primary Care Physician or Participating Medical Group in accordance with the terms of this Health Plan or were Emergency Services or Urgently Needed Services. This exclusion does not restrict UnitedHealthcare's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state or county hospital; however,

UnitedHealthcare's liability with respect to expenses for Covered Services provided in a state hospital is limited to the rate UnitedHealthcare would pay for those Covered Services if provided by a Participating Hospital.

34. **Hearing Aids and Hearing Devices** – Hearing aids, including repairs and replacements, are covered up to the limits described in the *Schedule of Benefits*. Replacement of a hearing aid is only covered when the condition of the device or part requires repairs that exceed the cost of a replacement hearing aid. Hearing aids or hearing devices are limited to one hearing aid (including repair or replacement) per hearing impaired ear every three years.

35. **Hospice Services** – Hospice services are not covered for:

    a. Members who do not meet the definition of terminally ill. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one year if the disease follows its natural course.

    b. Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a non-certified Hospice program).

    Note: Hospice services provided by a Non-Participating Hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice agencies and only when prior authorized and arranged by UnitedHealthcare or the Member's Participating Medical Group.

36. **Human Growth Hormone** – Human growth hormone injections for the treatment of idiopathic short stature are covered only when determined Medically Necessary by a UnitedHealthcare Medical Director or designee.

37. **Immunizations** – Immunizations and vaccines solely for international travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered, except as otherwise recommended by the national advisory organizations referenced in the section, "Outpatient Benefits", "Preventive Care Services." Routine boosters and immunizations must be obtained through the Member's Participating Medical Group.

38. **Implants** – The following implants and services are not covered:

    - Surgical implantation or removal of breast implants for nonmedical reasons.
    - Replacement of breast implants when the initial surgery was done for non-medical reasons, such as for cosmetic breast augmentation mammoplasty or after cosmetic breast reduction mammoplasty.

    UnitedHealthcare will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care.

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

40. **Infertility Services** – Infertility services (including artificial insemination), except as excluded in the General Exclusions and Limitations, including professional, hospital, ambulatory surgery center, ancillary services and injectable drugs administered or prescribed by the provider to diagnose and treat the cause of infertility.

41. **Institutional Services and Supplies** – Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled nursing services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections entitled "Inpatient Benefits" and "Outpatient Benefits.") Members residing in these Facilities are eligible for Covered Services that are determined to be Medically Necessary by

Member's Participating Medical Group or UnitedHealthcare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or UnitedHealthcare.

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

43. **Mental Health and Nervous Disorders** – Mental Health Services are not covered except for diagnosis and treatment of Severe Mental Illness for adults and children, and for diagnosis and treatment of Serious Emotional Disturbances of Children. Please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage. Educational services for Developmental Delays and Learning Disabilities are not health care services and are not covered. (For information regarding excluded Educational Services, please refer to "Educational Services.")

44. **Non-Physician Health Care Practitioners** – This Plan may not cover services of all Non-Physician Health Care Practitioners. Participating Qualified Autism Service Providers, Participating Qualified Autism Service Professionals, Participating Qualified Autism Service Paraprofessionals are covered when criteria are met as authorized by your Participating Medical Group or UnitedHealthcare. Treatment by other Non-Physician Health Care Practitioners, such as acupuncturists and chiropractors may be available if purchased as a supplemental benefit. (For coverage of Severe Mental Illnesses (SMI) of adults and children, and for children, the treatment of Serious Emotional Disturbances (SED), refer to "Inpatient" and "Outpatient Benefits, Mental Health Services.")

45. **Nurse Midwife Services** – Licensed/Certified nurse midwife services are covered only when available within the Member's Participating Medical Group. Elective home deliveries are not covered.

46. **Nursing Services, Private Duty** – Private-Duty Nursing Services are not covered. Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the Hospital or Skilled Nursing Facility.

47. **Nutritional Supplements or Formulas** – Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the Outpatient description of "Phenylketonuria (PKU) Testing and Treatment."

48. **Off-Label Drug Use** – Off-label drug use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved for by the FDA, including off-label self-injectable drugs, is not covered except as follows: If the self-injectable drug is prescribed for off-label use, the drug and its administration is covered only when the following criteria are met:

    - The drug is approved by the FDA;
    - The drug is prescribed by a Participating Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: (a) *The American Hospital Formulary Service 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,* or (c) in 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 a major peer-reviewed medical journal.

    Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary or Copayment.

49. **Oral Surgery and Dental Services** – Dental services, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered except for Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Refer to "Reconstructive Surgery" procedure.

50. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered. (Please see "Dental Care, Dental Appliances and Orthodontics" and "Dental Treatment Anesthesia.")

51. **Organ Donor Services** – Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. Donor searches are only covered when performed by a Provider included in the "Designated Facility."

52. **Organ Transplants** – All organ transplants must be Preauthorized by UnitedHealthcare and performed in a Designated Facility.

    - Transportation is limited to the transportation of the Member and one escort to a Designated Facility greater than 60 miles from the Member's Primary Residence as Preauthorized by UnitedHealthcare. Transportation and other nonclinical expenses of the living donor are excluded, and are the responsibility of the Member, who is the recipient of the transplant. (See the definition for "Designated Facility.")
    - Food and housing is not covered unless the Designated Facility is located more than 60 miles from the Member's Primary Residence, in which case food and housing is limited to $125 a day to cover both the Member and escort, if any (excludes alcohol and tobacco) as Preauthorized by UnitedHealthcare. Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
    - Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency (the agency that obtains the organ) is the same for both facilities. Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, UnitedHealthcare will only cover the costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the Facility where the transplant is performed. The Member is responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second Facility. (See the definition for "Regional Organ Procurement Agency" under "Designated Facility").
    - Artificial heart implantation and non-human organ transplantation are considered Experimental and are therefore excluded. Please refer to the exclusion entitled "Experimental and/or Investigational Procedures, Items and Treatment" and to the "Independent Medical Review" process outlined in **Section 8**.

53. **Pain Management** – Pain management services are covered for the treatment of chronic and acute pain only when they are received from a Participating Provider and authorized by UnitedHealthcare or its designee.

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

55. **Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other non-health reasons are not covered. Court-ordered or other statutorily allowed psychological evaluation, testing, and treatment are not covered unless

Medically Necessary and preauthorized by UnitedHealthcare for the diagnosis and treatment of a disease, including Severe Mental Illness or a Serious Emotional Disturbance of a Child, or illness. (For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*.)

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

57. **Prosthetics and Corrective Appliances/Non-Foot Orthotics** – Replacement of prosthetics or corrective appliances/non-foot orthotics are covered when determined Medically Necessary by the Member's Participating Medical Group or UnitedHealthcare. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered. Deluxe upgrades that are not Medically Necessary are not covered. For a detailed listing of covered durable medical equipment and prosthetics and corrective appliances, please contact the UnitedHealthcare Customer Service department at 1-877-359-3714.

58. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by a UnitedHealthcare Medical Director or designee.

59. **Reconstructive Surgery** – Reconstructive surgeries are not covered under the following circumstances:

    - When there is another more appropriate surgical procedure that has been offered to the Member; or
    - When only a minimal improvement in the Member's appearance is expected to be achieved.

    Preauthorizations for proposed reconstructive surgeries will be reviewed by Physicians specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

60. **Recreational, Lifestyle, or Hypnotic Services** – Recreational, lifestyle, or hypnotic services, and related testing are not covered. Recreational therapy services are only covered when they are authorized, part of a Medically Necessary treatment plan, provided by a Participating Provider who is a registered physical, speech or occupational therapist or a health care professional under the direct supervision of a licensed physical therapist acting within the scope of his or her license or as authorized under California law. See "Inpatient Rehabilitation Care" under "Inpatient Benefits" and Outpatient Medical Rehabilitation Therapy under "Outpatient Benefits" for an explanation of coverage of physical, occupational and speech therapy.

61. **Rehabilitation Services and Therapy** – Rehabilitation services and therapy will be provided only as Medically Necessary and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law and are either limited or not covered, as follows:

    - Speech, occupational or physical therapy is not covered when medical or mental health documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals.
    - Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by an illness, including Severe Mental Illness and Serious Emotional Disturbances of a Child, injury or surgery (for example, cleft palate repair) and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law.
    - Cognitive Rehabilitation Therapy is limited to neuropsychological testing by an authorized Physician or Provider acting within the scope of his or her license or as authorized under California law and the Medically Necessary treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult or when provided as part of an authorized autism behavioral health treatment plan. This benefit is limited to Outpatient rehabilitation limitation, if any and inpatient only when a Member also meets criteria for inpatient medical rehabilitation services.

- Developmental Testing beyond initial diagnosis is limited to Medically Necessary testing for medical conditions, pervasive developmental disorders and autism.
- Exercise programs are only covered when they are part of an authorized treatment plan and require the direct supervision of a licensed physical therapist and are provided by a Participating Provider acting within his or her license or as authorized under California law.
- Activities that are solely recreational, social or for general fitness, such as gyms and dancing classes, are not covered.
- Aquatic/pool therapy is not covered unless part of an authorized treatment plan and conducted by a licensed physical therapist and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law.
- Massage therapy is not covered except if it is part of a physical therapy treatment plan and covered under "Inpatient Hospital," "Outpatient Services," "Home Health Care," "Hospice Services," or "Skilled Nursing Care" in this Evidence of Coverage.

The following Rehabilitation Services, special evaluations and therapies are not covered:

- Biofeedback (except when Medically Necessary for the treatment of urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.)
- Cognitive Behavioral Therapy, unless Medically Necessary and provided by a Participating Provider acting within the scope of his or her license or as authorized under California law.
- Hypnotherapy
- Psychological Testing unless Medically Necessary to diagnose and treat an illness, including Severe Mental Illness and Serious Emotional Disturbances of a Child, or injury, and authorized.
- Vocational Rehabilitation

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

62. **Respite Care** – Respite care is not covered, unless part of an authorized Hospice plan and is necessary to relieve the primary caregiver in a Member's residence. Respite care is covered only on an occasional basis, not to exceed five consecutive days at a time.
63. **Routine Laboratory Testing Out-of-Area** – Routine laboratory tests are not a covered benefit while the Member is outside of the geographic area served by the Member's Participating Medical Group. Although it may be Medically Necessary, out-of-area routine laboratory testing is not considered an Urgently Needed Service because it is not unforeseen and is not considered an Emergency Service.
64. **Third-Party Liability** – Expenses incurred due to liable third parties are not covered, as described in the section "UnitedHealthcare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."
65. **Services Provided at No Charge to Member** – Services and supplies that are provided free of charge if the Member did not have coverage under this Health Plan or for which the Member will not be held financially responsible, unless UnitedHealthcare has agreed to payment arrangements prior to the provision of the services or supplies to the Member.
66. **Sexual Dysfunction or Inadequacy Medications** – Sexual dysfunction or inadequacy medications/drugs, procedures, services, and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels, are not covered.
67. **Substance-Related and Addictive Disorder Rehabilitation** – Inpatient, Outpatient and day treatment rehabilitation for chronic Substance-Related and Addictive Disorder is not covered. Methadone treatment

for detoxification is not covered. (Coverage for rehabilitation of Substance-Related and Addictive Disorder may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's health plan includes a Behavioral health supplemental benefit, a brochure describing it will be enclosed with these materials.)

Not Covered:

- Rapid anesthesia opioid detoxification;
- Substance-Related and Addictive Disorder rehabilitation services are not covered; except if the Subscriber's Employer Group has purchased the supplemental Behavioral Health Benefit;
- Services that are required by a court order as a part of parole or probation, or instead of incarceration.

68. **Surrogacy** – Infertility and maternity services for non-Members are not covered.
69. **Transportation** – Transportation is not a covered benefit except for ambulance transportation as defined in this *Combined Evidence of Coverage and Disclosure Form*. Also see "Organ Transplants" listed in "Other Exclusions and Limitations."
70. **Vision Care** – See "Eyewear and Corrective Refractive Procedures" listed in "Other Exclusions and Limitations."
71. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
72. **Visual Aids** – Visual aids are not covered, except as specified under the outpatient benefit for "Diabetic Self-Management Items." Electronic and non-electronic magnification devices are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit.)
73. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered. These programs include, but are not limited to, dietary evaluations, counseling, exercise, behavioral modification, food and food supplements, vitamins and other nutritional supplements. Also excluded are non-authorized weight loss program laboratory tests associated with monitoring weight loss or weight gain, except as described under Inpatient benefits "Morbid Obesity (Surgical Treatment)." For the treatment of anorexia nervosa and bulimia nervosa, please refer to the behavioral health supplement of your *Combined Evidence of Coverage and Disclosure Form*.

SECTION 6. PAYMENT RESPONSIBILITY

- **Premiums and Copayments**
- **What to Do if You Receive a Bill**
- **Coordinating Benefits With Another Plan**
- **Medicare Eligibility**
- **Workers' Compensation Eligibility**
- **Other Benefit Coordination Issues**

One of the advantages of your health care coverage is that most out-of-pocket expenses are limited to Copayments. This section explains these and other health care expenses. It also explains your responsibilities when you are eligible for Medicare or workers' compensation coverage and when UnitedHealthcare needs to coordinate your benefits with another plan.

What are Premiums (Prepayment Fees)?

Premiums are fees an Employer Group pays to cover the basic costs of your health care package. An Employer Group usually pays these Premiums on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary.

If you are the Subscriber, you should already know if you are contributing to your Premium payment; if you aren't sure, contact your Employer Group's health benefits representative. He or she will know if you are contributing to your Premium, as well as the amount, method and frequency of this contribution.

What are Copayments (Other Charges)?

Aside from the Premium, you may be responsible for paying a charge when you receive a Covered Service. This charge is called a Copayment and is outlined in your *Schedule of Benefits*. If you review your *Schedule of Benefits*, you will see that the amount of the Copayment depends on the service, as well as the Provider from whom you choose to receive your care.

Annual Copayment Maximum

For certain Covered Services, there is a limit placed on the total amount you pay for Copayments during a calendar year. This limit is called your Annual Copayment Maximum and when you reach it, for the remainder of the calendar year, you will not pay any additional Copayments for these Covered Services. Copayments paid for certain Covered Services are not applicable to a Member's Annual Copayment Maximum; these services are specified in the *Schedule of Benefits*.

Note: The calculation of your Annual Copayment Maximum will exclude supplemental benefits that may be offered by your Employer Group (e.g., coverage for Outpatient prescription drugs, Infertility Services and drugs). See your CVS Caremark Evidence of Coverage (EOC) regarding your applicable outpatient pharmacy copay limits.

If You Get a Bill (Reimbursement Provisions)

If you are billed for a Covered Service provided or authorized by your Primary Care Physician or Participating Medical Group or if you receive a bill for Emergency or Urgently Needed Services you should do the following:

1. Call the Provider, then let them know you have received a bill in error and you will be forwarding the bill to UnitedHealthcare.
2. Give the Provider your UnitedHealthcare Health Plan information, including your name and UnitedHealthcare Member number.
3. Forward the bill to:

UnitedHealthcare of California
Claims Department UHC West-CalPERS
PO Box 30510
Salt Lake City, UT 84130-0510

Include your name, your UnitedHealthcare ID number and a brief note that indicates you believe the bill is for a Covered Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required. If you need additional assistance, call our Customer Service department.

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

What is a *Schedule of Benefits*?

Your *Schedule of Benefits* is printed separately from this document and lists the Covered Services unique to your plan. It also includes your Copayments, as well as the Annual Copayment Maximum and other important information. If you need assistance understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service department.

Bills from Non-Participating Providers

If you receive a bill for a Covered Service from a Physician who is not one of our Participating Providers, and the service was Preauthorized and you haven't exceeded any applicable benefit limits, UnitedHealthcare will pay for the service, less the applicable Copayment. (Preauthorization isn't required for Emergency Services and Urgently Needed Services. See **Section 3. Emergency and Urgently Needed Services.**) You may also submit a bill to us if a Non-Participating Provider has refused payment directly from UnitedHealthcare.

You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

UnitedHealthcare of California
Claims Department
UHC West-CalPERS
PO Box 30510
Salt Lake City, UT 84130-0510

Include your name, UnitedHealthcare Health Plan ID number and a brief note that indicates your belief that you have been billed for a Covered Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required.

UnitedHealthcare will make a determination within 30 working days from the date UnitedHealthcare receives a claim containing all information reasonably necessary to decide the claim. UnitedHealthcare will not pay any claim that is filed more than 180 calendar days from the date the services or supplies were provided. UnitedHealthcare also will not pay for excluded services or supplies unless authorized by your Primary Care Physician, your Participating Medical Group or directly by UnitedHealthcare.

Any payment assumes you have not exceeded your benefit limits. If you have reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How to Avoid Unnecessary Bills

Always obtain your care under the direction of UnitedHealthcare, your Participating Medical Group, or your Primary Care Physician. By doing this, you only will be responsible for paying any related Copayments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by UnitedHealthcare or your Participating Medical Group, you may be responsible for

payment. This is also true if you receive any services not covered by your plan. (Services not covered by your plan are included in **Section 5. Your Medical Benefits**.)

Your Billing Protection

All UnitedHealthcare Members have rights that protect them from being charged for Covered Services in the event a Participating Medical Group does not pay a Provider, a Provider becomes insolvent or a Provider breaches its contract with UnitedHealthcare. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Benefits*.)

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

Note: If you receive a bill because a Non-Participating Provider refused to accept payment from UnitedHealthcare, you may submit a claim for reimbursement. See above: "Bills From Non-Participating Providers."

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. "Plan" is defined below. COB is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group Health Plans that provide coverage to an individual will pay no more than 100 percent of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group Health Plan provides benefits in the form of services rather than cash payments.

UnitedHealthcare's COB activities will not interfere with your medical care.

The order of benefit determination rules below determines which Health Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans does not exceed 100 percent of the total allowable expense. "Allowable Expense" is defined below.

Definitions

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

   1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a "Plan" as defined here; however, UnitedHealthcare does coordinate benefits with Medicare. Please refer to **Section 6,** "Important Rules for Medicare and Medicare Eligible Members."

   2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of Hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement

policies, a state plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or above is a separate Plan. However, if the same carrier provides coverage to Members of a group under more than one group contract each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense** means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are **not** Allowable Expenses:

1. If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room; (unless the patient's stay in a private Hospital room is Medically Necessary) is not an Allowable Expense.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.
5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that has contracted with, or is employed by, the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.

F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group Health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among UnitedHealthcare and other applicable group Health Plans by establishing which plan is primary, secondary and so on:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent; for example as an employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

   a. **Birthday Rule.** The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the Eligibility section of this *Combined Evidence of Coverage and Disclosure Form*. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.

   c. If the parents are not married and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

      - The Plan of the Custodial Parent;
      - The Plan of the Spouse or Domestic Partner of the Custodial Parent;
      - The Plan of the non-Custodial Parent; and then
      - The Plan of the Spouse of the non-Custodial Parent.

3. **Active or Inactive Employee.** The Plan that covers a person as an employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working Spouse or Domestic Partner will be determined under the rule labeled D(1).

4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree (or as that person's Dependent)

is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order of payment, the Plan that covered the person as an employee, Member, Subscriber or retiree for the longer period is primary.

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 during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person having received services from a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

UnitedHealthcare may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this Plan must give UnitedHealthcare any facts it needs to apply those rules and determine benefits payable. UnitedHealthcare may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including, but not limited to, diagnoses payment of health care services rendered, billing, claims management or other administrative functions of UnitedHealthcare, without obtaining the Member's consent, in accordance with state and federal law.

UnitedHealthcare's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, UnitedHealthcare may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. UnitedHealthcare will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" includes providing benefits in the form of services, in which case, "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Important Rules for Medicare and Medicare-Eligible Members

You must let UnitedHealthcare know if you are enrolled, or eligible to enroll, in Medicare (Part A and/or Part B coverage). UnitedHealthcare is typically primary (that is, UnitedHealthcare's benefits are determined before those of Medicare) to Medicare for some initial period of time, as determined by the Medicare regulations. After the initial period of time, UnitedHealthcare will be secondary to Medicare (that is, the benefits under this Health Plan will be reduced to the extent they duplicate any benefits provided or available under Medicare, if the Member is enrolled or eligible to enroll in Medicare.)

If you have questions about the coordination of Medicare benefits, contact your Employer Group or our Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers' Compensation

UnitedHealthcare will not provide or arrange for benefits, services or supplies required as a result of a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers' Compensation Act, occupational disease laws, employer's liability or federal, state or municipal law, To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers' Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers' Compensation Appeals Board, if necessary.

If for any reason UnitedHealthcare provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse UnitedHealthcare for the benefits, services or supplies provided or arranged for, at Prevailing Rates, immediately after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected as a result of a workers' compensation action in trust for UnitedHealthcare. This award will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits furnished to him or her or on his or her behalf by UnitedHealthcare for each incident. If the Member receives a settlement from workers' compensation coverage that includes payment of future medical costs, the Member must reimburse UnitedHealthcare for any future medical expenses associated with this judgment if UnitedHealthcare covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, UnitedHealthcare will provide or arrange for benefits until such dispute is resolved, if the Member signs an agreement to reimburse UnitedHealthcare for 100 percent of the benefits provided.

UnitedHealthcare will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions of law under the Workers' Compensation Act. Benefits will not be denied to a Member whose employer has not complied with the laws and regulations governing workers' compensation insurance, provided that such Member has sought and received Medically Necessary Covered Services under this Health Plan.

Payment Responsibility When an Injury or Sickness is caused by a Third Party's Act or Omission

Applicability

This provision applies when a Member suffers an injury or sickness through an act or omission of another person(s) (the "third party").

Third-Party Liability – Expenses Incurred Due to Liable Third Parties Are Not Covered

Health care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, UnitedHealthcare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned "UnitedHealthcare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."

UnitedHealthcare's Right to the Repayment of a Debt as a Charge against Recoveries from Third Parties Liable for a Member's Health Care Expenses

Expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, UnitedHealthcare will pay for the arrangement or provision of health care

services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the following agreement:

If a Member is injured by a liable third party, the Member agrees to give UnitedHealthcare, or its representative, agent or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to UnitedHealthcare, which debt shall include the cost of arranging or providing otherwise covered health care services to the Member for the care and treatment that was necessary because of a liable third party.

The security interest the Member grants to UnitedHealthcare, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Member's health care services for injuries caused by a liable third party.

Non-Duplication of Benefits with Automobile, Accident or Liability Coverage

If you are receiving benefits as a result of automobile, accident or liability coverage, UnitedHealthcare will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected and to notify UnitedHealthcare of such coverage when available. UnitedHealthcare will provide Covered Services over and above your automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

SECTION 7. MEMBER ELIGIBILITY

- **Membership Requirements**
- **Adding Family Members**
- **Late Enrollment**
- **Updating Your Enrollment Information**
- **Termination of Enrollment**
- **Coverage Options Following Termination**

This section describes how you become a UnitedHealthcare Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your UnitedHealthcare coverage when it would otherwise terminate.

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, termination of coverage, and conversion rights can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Member Account Management Division at:

CalPERS
Member Account Management Division
P.O. Box 942714
Sacramento, CA 94229-2714

Or call:

888 CalPERS (or **888**-225-7377)

(916) 795-3240 (TDD)

Who is a UnitedHealthcare Member?

There are two kinds of UnitedHealthcare Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or her employer-sponsored health benefits plan. The Employer Group, in turn, has signed a Group Agreement with UnitedHealthcare.

The following Family Members are eligible to enroll in UnitedHealthcare:

1. The Subscriber's Spouse or Domestic Partner,
2. The biological children of the Subscriber or the Subscriber's Spouse or the Domestic Partner (stepchildren) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age," see **Definitions**);
3. Children who are legally adopted or placed for adoption with the Subscriber, the Subscriber's Spouse or the Domestic Partner who are under the Limiting Age established by the employer;
4. Children for whom the Subscriber, the Subscriber's Spouse or Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to UnitedHealthcare upon request; and

5. Children for whom the Subscriber, the Subscriber's Spouse or Domestic Partner is required to provide health insurance coverage pursuant to a qualified medical child support order assignment order, or medical support order, in this section.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- Was born to a single person or unmarried couple;
- Is not claimed as a Dependent on a federal income tax return;
- Does not reside with the Subscriber or within the UnitedHealthcare Service Area.

Effective Date of Coverage for New Subscribers and Family Members to Be Added Outside Open Enrollment

Coverage for a newly enrolled Subscriber and his or her eligible Family Members begins on the date agreed to by the Employer Group or under the terms of the signed Group Agreement provided we receive the completed enrollment form and any required Health Plan Premium within 30 days of the date the Subscriber becomes eligible to enroll in the Health Plan.

The effective date of enrollment when adding Family Members outside of the initial or Open Enrollment Period is explained below. (**Please Note:** UnitedHealthcare enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.)

What is a Service Area?

UnitedHealthcare is licensed by the California Department of Managed Health Care to arrange for medical and Hospital Services in certain geographic areas of California. These service areas are defined by ZIP Codes. Please call our Customer Service department for information about UnitedHealthcare's Service Area.

Open Enrollment

Most Members enroll in UnitedHealthcare during the "Open Enrollment Period" established by the Employer Group. This is the period of time established by the employer when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefits plan. An Open Enrollment Period usually occurs once a year, and enrollment is effective based on a date agreed upon by the employer and UnitedHealthcare.

Adding Family Members to Your Coverage

The Subscriber's Spouse or Domestic Partner and eligible children may apply for coverage with UnitedHealthcare during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health plan insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in UnitedHealthcare if you and your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the Employer Group stops contributing toward your or your Dependents' other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period. To obtain more information, contact our Customer Service department.

1. **Getting Married.** When a new Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the date of the marriage if we receive a completed application to enroll a Spouse or child eligible as a result of marriage within 30 days of the marriage.

2. **Domestic Partnership.** When a new Domestic partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Having a Baby**. Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, a Change Request Form must be submitted to UnitedHealthcare prior to the expiration of the 30-day period.
4. **Adoption or Placement for Adoption.** Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization form or a relinquishment form, granting Subscriber, Subscriber's Spouse or Domestic Partner the right to control the health care for the adoptive child. or absent such a document, on the date there exists evidence of the Subscriber's Spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
5. **Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's Spouse or Domestic Partner has assumed legal guardianship, the Subscriber must submit a Change Request Form to UnitedHealthcare along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber, Subscriber's Spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in UnitedHealthcare) may enroll a child who is eligible to enroll in UnitedHealthcare upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a UnitedHealthcare Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling UnitedHealthcare's Customer Service department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the Health Plan ID card, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the date of the court or administrative order provided we receive the completed enrollment form with the court or administrative order attached and any required Health Plan Premium.

Except for Emergency and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the UnitedHealthcare Service Area by the designated Participating Medical Group, as selected by the custodial parent or person having legal custody.

Continuing Coverage for Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Health Plan due to their attainment of the Limiting Age established by the Employer Group may extend their coverage under the following circumstances:

A Dependent residing outside of the Service Area must maintain a permanent address inside the Service Area and must select a Participating Medical Group within 30 miles of that address. All health care coverage must be provided or arranged for in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services. A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents who attain the Limiting Age may continue enrollment in the Health Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. The unmarried Dependent is chiefly Dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Dependent reaching the Limiting Age, UnitedHealthcare will send notice to you, the Subscriber, that coverage for the disabled Dependent will terminate at the end of the Limiting Age unless proof of such incapacity and dependency is provided to UnitedHealthcare by the Member within 60 days of receipt of notice. UnitedHealthcare shall determine if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until UnitedHealthcare makes a determination.

UnitedHealthcare may require ongoing proof of a Dependent's incapacity and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, UnitedHealthcare may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide UnitedHealthcare with the requested information within 60 days of receipt of the request. The child must have been covered as a dependent of the Subscriber or Spouse under a previous health plan at the time the child reached the age limit.

Late Enrollment

In addition to a special enrollment period due to the addition of a new Spouse, Domestic Partner or child, there are certain circumstances when employees and their eligible Family Members may enroll outside of the employer's Open Enrollment Period. These circumstances include:

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in UnitedHealthcare when they were first eligible because they had other health care coverage; and
2. UnitedHealthcare cannot produce a written statement from the Employer Group or eligible employee stating that prior to declining coverage, the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with, and signed, acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage with UnitedHealthcare during the initial enrollment period permits the Company to impose, beginning on the date the eligible employee (on his or her behalf, or on behalf of any eligible Dependents) elects coverage under the Health Plan, an exclusion of coverage under the Health Plan for a period of 12 months unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.
3. The other health care coverage is no longer available due to:
    a. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or
    b. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
    c. The termination of the other Health Plan coverage; or
    d. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or

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

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

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

h. The employee or eligible Family Member previously declined coverage under the Health Plan, but the employee or eligible Family Member becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP), or the AIM Program. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date of the determination of subsidy eligibility; or

i. The employee or eligible Family Member loses eligibility under Medicare or Children's Health Insurance Program (CHIP), the AIM Program, or the Medi-Cal program. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date coverage ended.

4. The Court has ordered health care coverage be provided for your Spouse or minor child.

5. Dependent Child Special Enrollment Period – On or before the first day of the first plan year beginning on or after September 23, 2010, the Employer Group will provide a 30-day Dependent Child Special Enrollment Period for Dependent children who are not currently enrolled under the Health Plan and who have not yet reached the Limiting Age. During this Dependent child special enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options. If a Dependent child qualifies for an enrollment opportunity under this Dependent Child Special Enrollment and the parent is not enrolled but is otherwise eligible for enrollment, the parent may enroll with the child during this special enrollment period. Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Health Plan Premium within 31 days of the date the Dependent becomes eligible to enroll under this special enrollment period.

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

Notifying You of Changes in Your Plan

Amendments, modifications or termination of the Group Agreement by either the Employer Group or UnitedHealthcare do not require the consent of a Member. UnitedHealthcare may amend or modify the Health Plan, including the applicable Premiums, at any time after sending written notice to the Employer Group 60 days prior to the effective date of any amendment or modification. Your Employer Group may also change your Health Plan benefits during the contract year. In accordance with UnitedHealthcare's Group Agreement, the Employer Group is obliged to notify employees who are UnitedHealthcare Members of any such amendment or modification.

Updating Your Enrollment Information

Please notify your employer and UnitedHealthcare of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see "Adding Family Members to Your Coverage." If you wish to change your Primary

Care Physician or Participating Medical Group, you may contact UnitedHealthcare's Customer Service department at 1-877-359-3714 or 711 (TTY).

Renewal and Reinstatement (Renewal Provisions)

Your Employer Group's Group Agreement with UnitedHealthcare renews automatically, on a yearly basis, subject to all terms of the Group Agreement. UnitedHealthcare or your Employer Group may change your Health Plan benefits and Premium at renewal. If the Group Agreement is terminated by UnitedHealthcare, reinstatement is subject to all terms and conditions of the Group Agreement. In accordance with UnitedHealthcare's Group Subscriber Agreement, the Employer Group is required to notify employees who are UnitedHealthcare Members of any such amendment or modification.

About Your UnitedHealthcare Health Plan Identification (ID) Card

Your UnitedHealthcare Health Plan ID card is important for identifying you as a Member of UnitedHealthcare. Possession of this card does not entitle a Member to services or benefits under this Health Plan. A Member should show this card each time he or she visits a Primary Care Physician or upon referral, any other Participating Provider.

Important Note: Any person using this card to receive benefits or services for which he or she is not entitled will be charged for such benefits or services. If any Member permits the use of his or her identification card by any other person, UnitedHealthcare may immediately terminate that Member's membership.

Ending Coverage (Termination of Benefits)

Usually, your enrollment in UnitedHealthcare terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health benefits plan. In most instances, your Employer Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Health Plan is subject to the terms and conditions of the employer's Group Agreement with UnitedHealthcare.

When the Group Agreement between the Employer Group and UnitedHealthcare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by UnitedHealthcare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated at the end of the 30-day grace period. The grace period begins after the last day of paid coverage. UnitedHealthcare will continue to provide coverage during the grace period. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated, except in the event the Group Agreement is terminated for the nonpayment of Health Plan Premiums. In that circumstance, UnitedHealthcare will notify you directly of such termination.

Termination and Rescission of Coverage

UnitedHealthcare has the right to terminate your coverage under this Health Plan in the following situations:

- **For Nonpayment of Premiums.** Your coverage may be terminated if the Employer Group failed to pay the required Premiums. UnitedHealthcare will mail your Employer a notice at least 30 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the Premiums due within 30 days of the date the notice was mailed.

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

  - That the Group Contract has been cancelled for nonpayment of Premiums.
  - The specific date and time when your Group coverage ended.

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

Reinstatement of the Contract after Cancellation due to Nonpayment of Premiums

If the Group Contract is cancelled for the group's nonpayment of Premiums, the Plan will permit reinstatement of the Group Contract once during any 12-month period if the group pays the amounts owed within 30 days of the date of the Notice Confirming Termination.

- **For Fraud or Intentional Misrepresentation of a Material Fact by Member.** Your coverage may be rescinded if you intentionally misrepresent a material fact on your enrollment form or commit fraud which may include, but not be limited to, deception in use of services or facilities of UnitedHealthcare, its Participating Medical Group or other health care Providers or intentionally allow another person to do the same or alter a prescription. Rescinding coverage means that the Group Agreement and *Combined Evidence of Coverage and Disclosure Form* are void and that no coverage existed at any time. UnitedHealthcare will send the Employer Group and you a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Managed Health Care.
- **For Fraud or Intentional Misrepresentation of a Material Fact by Employer Group.** Your coverage may be terminated, if your Employer Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of the Group Agreement (including any omissions, misrepresentations, or inaccuracies in the application form) or to the provision of coverage under the Group Agreement. Also, UnitedHealthcare has the right to rescind the Group Agreement back to either: (1) the date of the Group Agreement; or (2) the date of the act, practice or omission, if later. Rescinding coverage means that the Group Agreement and *Combined Evidence of Coverage and Disclosure Form* are void and that no coverage existed at any time. UnitedHealthcare will send the Employer Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Managed Health Care.
- **For Violation of Employer Group's Contribution or Group Participation Requirements.** Your coverage may be terminated if your Employer Group fails to meet the Group Contribution or Group Participation requirements as described in the Group Agreement.
- **For Discontinuance of this Health Plan.** Your coverage may be terminated if UnitedHealthcare decides to cease offering the Health Plan described in this *Combined Evidence of Coverage and Disclosure Form* upon 90 days written notice to the Director of the Department of Managed Health Care, the Employer Group and all Members covered under this Health Plan. If this Health Plan is discontinued, UnitedHealthcare will make all other health plans offered to new group business available to your Employer Group.
- **For Discontinuance of All New and Existing Health Plans.** Your coverage may be terminated if UnitedHealthcare decides to cease offering existing or new health plans in the group market in the State of California upon 180 days written notice to the Director of the Department of Managed Health Care, the Employer Group and all Members covered under this Health Plan.

If you believe your policy or coverage has been or will be wrongly canceled, rescinded or not renewed, please refer to "**Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan**" in **Section 8.**

Overseeing Your Health Care Decisions to learn how to request a review by the Department of Managed Care (DMHC) Director.

Other Reasons for Termination of Coverage Related to Loss of Eligibility

In addition to terminating the Group Agreement, UnitedHealthcare may terminate a Member's coverage for any of the following reasons related to loss of eligibility:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or UnitedHealthcare.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the State of California.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the UnitedHealthcare Service Area and does not work inside the UnitedHealthcare Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability"). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, contact our Customer Service department.

Note: If a Group Agreement is terminated by UnitedHealthcare, reinstatement with UnitedHealthcare is subject to all terms and conditions of the Group Agreement between UnitedHealthcare and the employer.

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there is a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they reach the Limiting Age established by the employer and do not qualify for extended coverage as a Dependent or as a disabled Dependent. Please refer to the section "Continuing Coverage for Certain Disabled Dependents." It may also end when a Dependent child reaches the Limiting Age. Please refer to "Extending Your Coverage" for additional coverage which may be available to you.

Total Disability

If the Group Agreement providing the Subscriber coverage is terminated, and the Subscriber or any enrolled Family Members are Totally Disabled on the date the Group Agreement is terminated, federal law may require the group's succeeding carrier to provide coverage for the treatment of the condition causing Total Disability. However, in the event that the Subscriber's group does not contract with a succeeding carrier for health coverage, or in the event that federal law would allow a succeeding carrier to exclude coverage of the condition causing the Total Disability for a period of time, UnitedHealthcare will continue to provide benefits to the Subscriber or any enrolled Family Member for Covered Services directly relating to the condition causing Total Disability existing at the time of termination, for a period of up to 12 successive months after the termination. The extension of benefits may be terminated by UnitedHealthcare at such time the Member is no longer Totally Disabled, or at such time as a succeeding carrier is required by law to provide replacement coverage to the Totally Disabled Member without limitation as to the disabling condition.

Coverage Options Following Termination (Individual Continuation of Benefits)

If your coverage through this *Combined Evidence of Coverage and Disclosure Form* ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Health Plan at group rates, plus an administration fee, in certain instances where your coverage under the Health Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable Premiums.

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

- Your hours of employment are reduced to less than the number of hours required for eligibility, or
- Your employment ends for any reason other than gross misconduct on your part.

If you are the Spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Health Plan because any of the following qualifying events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced to less than the number of hours required for eligibility;
3. Your Spouse's employment ends (for reasons other than his or her gross misconduct);
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage if group health coverage under this Health Plan is lost because any of the following qualifying events happens:

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;
3. Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscriber becomes divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

When is COBRA coverage available?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its

COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, Spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

You Must Give Notice of Some Qualifying Events

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

How is COBRA coverage provided?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Under federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. The date coverage ends due to a qualifying event; or
2. The date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Health Plan may elect COBRA continuation coverage on behalf of their Spouses and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the Subscriber's divorce or legal separation, or a Dependent child losing eligibility as a Dependent child under this Health Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA

continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not occurred.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA May Terminate Before Maximum Coverage Period Ends

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

1. Your Employer Group no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

COBRA Premium

Under the law, you may have to pay the entire premium for your continuation coverage. Premium for COBRA continuation coverage is generally 102 percent of the applicable Health Plan Premium. You are responsible for the timely submission of the COBRA premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to UnitedHealthcare.

If You Have Questions About COBRA

If you have any questions about your COBRA continuation coverage rights, please contact your Employer Group.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you by UnitedHealthcare at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began. At the end of the 36-month continuation coverage period, qualified beneficiaries may enroll in Covered California, California's Health Benefit Exchange, unless you are eligible for Medicare. (Other exclusions may apply. Please see the explanation under "Extending Your Coverage: Converting to an Individual Plan.") **Example:** As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify UnitedHealthcare within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from UnitedHealthcare. If you fail to notify UnitedHealthcare within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which occurred last. Your request must be in writing and delivered to UnitedHealthcare by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by UnitedHealthcare. You must pay your initial Premiums to UnitedHealthcare within 45 days from the date UnitedHealthcare mails your enrollment package after you notified UnitedHealthcare of your intent to enroll. Your first Premium must equal the full amount billed by UnitedHealthcare. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to UnitedHealthcare by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA, even if you enroll in UnitedHealthcare on or after January 1, 2003. Your qualifying event is the first day in which you were initially no longer eligible for your group Health Plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for UnitedHealthcare coverage, such as moving outside the UnitedHealthcare Service Area; or
5. The contract for health care services between your employer and UnitedHealthcare is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to UnitedHealthcare within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with UnitedHealthcare coverage, you may continue the remaining balance of your unused coverage with UnitedHealthcare, but only if you enroll with and pay Premiums to UnitedHealthcare within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and UnitedHealthcare terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Extending Your Coverage: Converting to an Individual Conversion Plan

If you have been enrolled in this Health Plan for three or more consecutive months, and you have been terminated by your employer which terminates your group Health Plan coverage, you and your currently enrolled

Family Members may apply for the Individual Conversion plan issued by UnitedHealthcare. The Employer Group is solely responsible for notifying you of the availability, terms and conditions of the Individual Conversion plan within 15 days of the termination of your group coverage.

An application for the conversion plan must be received by UnitedHealthcare within 63 days of the date of termination of your group coverage. However, if the Employer Group terminates its Group Agreement with UnitedHealthcare or replaces the UnitedHealthcare group coverage with another carrier within 15 days of the date of termination of the Group coverage or the Subscriber's participation, transfer to the Individual Conversion Health Plan is not permitted. You also will not be permitted to transfer to the Individual Conversion Health Plan under any of the following circumstances:

1. You failed to pay any amounts due to the Health Plan;
2. You were terminated by the Health Plan for fraud or intentional misrepresentation of a material fact as described in the section "Termination and Rescission of Coverage;"
3. You knowingly furnished incorrect information or otherwise improperly obtained benefits of the Health Plan;
4. You are covered or are eligible for Medicare;
5. You are covered or are eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured*;
6. The Employer Group's Hospital, medical or surgical expense benefit program is self-insured; or
7. You are covered for similar benefits under an Individual policy or contract.

Please Note: If you were not previously eligible under the UnitedHealthcare group Health Plan benefit as described above you may not enroll on UnitedHealthcare's Individual Conversion Plan. This includes any future Dependents not currently enrolled as a Member of your UnitedHealthcare group Health Plan under your former employer.

***Note also:** If you elect COBRA or California Continuation COBRA coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or California Continuation COBRA coverage ends. However, if you select Individual Conversion coverage instead, you will not be eligible for a HIPAA-guaranteed product.

Benefits or rates of an Individual Conversion plan Health Plan are different from those in your group plan. An Individual Conversion Health Plan is also available to:

1. Currently enrolled Dependents, if the Subscriber dies;
2. Dependents who are currently enrolled and are no longer eligible for group Health Plan coverage due either to marriage or exceeding the maximum age for Dependent coverage under the group plan, as determined by the employer;
3. Dependents who are currently enrolled and lose coverage as a result of the Subscriber entering military service;
4. Spouse of the Subscriber who is currently an enrolled Dependent under UnitedHealthcare, if your marriage has terminated due to divorce or legal separation.

Written applications and the first Premium payment for all conversions must be received by UnitedHealthcare within 63 days of the loss of group coverage. This is an additional option to UnitedHealthcare Members. This means you do not need to enroll and use any benefits you may have access to through COBRA or California Continuation COBRA to be eligible. For more details, please contact our Customer Service department.

Individual Conversion Plan Premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your Individual Conversion Plan Premium when the Premium payment is due, UnitedHealthcare will send you a 15-day cancellation notice reminding you that your Premium is overdue. If

Premium is received within 15 days of UnitedHealthcare's cancellation notification you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after UnitedHealthcare mailed the cancellation notice. A termination notice will be sent to you at that time and any Premium payments for coverage after the effective date of cancellation received after the 15-day notice period has expired will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for coverage prior to the effective date of cancellation.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by either UnitedHealthcare or the Employer Group when the Subscriber or a Dependent ceases to be eligible for benefits under the employer's health benefit plan. Certificates of Creditable Coverage will also be provided upon request while the Subscriber or Dependent is covered under the Health Plan and up to 24 months after coverage under the Health Plan ceases. A Certificate of Creditable Coverage may be used to reduce or eliminate a pre-existing condition exclusion period imposed by a subsequent Health Plan. Creditable coverage information for Dependents will be included on the Subscriber's Certificate, unless the Dependent's address of record or coverage information is substantially different from the Subscriber's. Please contact the UnitedHealthcare Customer Service department if you need a duplicate Certificate of Creditable Coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your Certificate of Creditable Coverage.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must select a Participating Medical Group within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services.

The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other UnitedHealthcare Members enrolled through your employer plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Health Plan Premiums from you or your Dependents and will forward your Health Plan Premiums to UnitedHealthcare along with your employer's Health Plan Premiums otherwise due under this Agreement. Additionally, your employer is responsible for maintaining accurate records regarding USERRA continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for UnitedHealthcare to administer this continuation benefit.

California Military Families Financial Relief Act

Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Member Service for information on how to apply for reinstatement of coverage following active duty as a reservist.

SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

- **How UnitedHealthcare Makes Important Decisions**
- **What to Do if You Have a Problem**
- **Quality of Care Review**
- **Appeals and Grievances**
- **Independent Medical Reviews**

This section explains how UnitedHealthcare authorizes or makes changes to your health care services, how we evaluate new health care technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your health care plan, including how to appeal a health care decision by UnitedHealthcare or one of our Participating Providers. You will learn the process that's available for filing a formal Grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How UnitedHealthcare Makes Important Health Care Decisions

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may be conducted by UnitedHealthcare, or in many situations, by a Participating Medical Group. Processes are used to review, approve, modify or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

Medical Necessity refers to an intervention as defined in **Section 10: Definitions**. A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

The reviewer may also use criteria or guidelines to determine whether to approve, modify or deny, based on Medical Necessity, requests by Providers of health care services for Members. The criteria used to modify or deny requested health care services in specific cases will be provided free of charge to the Provider, the Member and the public upon request.

Decisions to deny or modify requests for authorization of health care services for a Member, based on Medical Necessity, are made only by licensed Physicians or other appropriately licensed health care professionals.

The reviewer makes these decisions within at least the following time frame required by state law:

- Decisions to approve, modify or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five business days from UnitedHealthcare's, or in many situations, the Participating Medical Group's receipt of the information reasonably necessary and requested to make the decision.
- If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, but not later than 72 hours after UnitedHealthcare's or in many situations, the Participating Medical Group's receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because (i) UnitedHealthcare, or in many situations the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii consultation by an expert reviewer is required, or (iii) the reviewer has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, the reviewer will notify the Provider and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as UnitedHealthcare or the Participating Medical Group becomes aware that they will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by UnitedHealthcare, or in many situations the Participating Medical Group, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

The reviewer will notify requesting Providers of decisions to approve, modify or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny, delay or modify requested health care services, in writing, within two business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with UnitedHealthcare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an “Urgent Request,” as defined above, the reviewer will approve, modify or deny the request as soon as possible, taking into account the Member’s medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to UnitedHealthcare or, in many situations the Participating Medical Group at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, the reviewer will treat the request as a new request for a Covered Service under the Health Plan and will follow the time frame for non-urgent requests as discussed above.

If you would like a copy of UnitedHealthcare’s policy and procedure, a description of the processes utilized for the authorization, modification or denial of health care services, or is seeking information about the utilization management process and the authorization of care; you may contact the UnitedHealthcare Customer Service department at 1-877-359-3714.

UnitedHealthcare’s Utilization Management Policy

UnitedHealthcare distributes its policy on financial incentives to all its Participating Providers, Members and employees. UnitedHealthcare also requires that Participating Providers and staff who make utilization decisions, and those who supervise them, sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. UnitedHealthcare does not specifically reward Participating Providers or other individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage decisions that result in either the denial or modification of Medically Necessary Covered Services.

Medical Management Guidelines

The Medical Management Guidelines Committee (MMGC), consisting of UnitedHealthcare Medical Directors, provides a forum for the development, review and adoption of medical management guidelines to support consistent, appropriate medical care determinations. The MMGC develops guidelines using evidence-based medical literature and publications related to medical treatment or service. The Medical Management Guidelines contain practice and utilization criteria for use when making coverage and medical care decisions prior to, subsequent to or concurrent with the provisions of health care services.

Technology Assessment

UnitedHealthcare regularly reviews new procedures, devices, and drugs to determine whether or not they are safe and efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Copayments, or other payment contributions.

In determining whether to cover a service, UnitedHealthcare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, a UnitedHealthcare Medical Director makes a Medical Necessity determination based on individual Member medical documentation, review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Utilization Criteria

When a Provider or Member requests Preauthorization of a procedure/service requiring Preauthorization, an appropriately qualified licensed health professional reviews the request. The qualified licensed health professional applies the applicable criteria, including, but not limited to:

- Nationally published guidelines for utilization management (Specific guideline information available upon request.
- HCIA-Sachs Length of Stay© Guidelines (average length of Hospital stays by medical or surgical diagnoses)
- UnitedHealthcare Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP). (UnitedHealthcare's Medical Management Guideline Manual and Commercial HMO Benefit Interpretation Policy Manual are available at **www.uchwest.com**.)

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Participating Medical Group's Medical Director or a UnitedHealthcare Medical Director.

Denial, delay or modification of health care services based on Medical Necessity must be made by an appropriately qualified licensed Physician or a qualified licensed health professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.

Denials may be made for reasons other than Medical Necessity that include, but are not limited to, the fact that the patient is not a UnitedHealthcare Member or that the service being requested is not a benefit provided by the Member's plan.

Preauthorization determinations are made once UnitedHealthcare or Member's Participating Medical Group Medical Director or designee receives all reasonably necessary medical information.

UnitedHealthcare makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with state and federal requirements.

What to Do if You Have a Problem

Sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We will assist you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section 2. Seeing the Doctor**.

If you feel that your problem is not resolved or that your situation requires additional action, you may also submit a Grievance requesting an Appeal or Quality Review. To learn more about this, read the following section: "Appealing a Health Care Decision or Requesting a Quality of Care Review."

Appealing a Health Care Decision or Requesting a Quality of Care Review

Submitting a Grievance

UnitedHealthcare's Grievance system provides Members with a method for addressing Member dissatisfaction regarding coverage decisions, care or services. Our appeals and quality of care review procedures are designed to resolve your Grievance. This is done through a process that includes a thorough and appropriate investigation. To initiate an appeal or request a quality of care review, call our Customer Service department at
1-877-359-3714, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at **www.uhc.com/calpers** or write to the Appeals Department at:

Appeals & Grievances
UnitedHealthcare
P.O. Box 6107
Mail Stop CA124-0160
Cypress, CA 90630-9972

This request will initiate the following Appeals Quality of Clinical Care and Quality of Service 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 appeal regardless of whether this information was submitted or considered in the initial determination. 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.

UnitedHealthcare will review your complaint and if it involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer, a health care professional who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

Quality of Clinical Care and Quality of Service Review

All quality of clinical care and quality of service complaints are investigated by UnitedHealthcare's Health Services Department. UnitedHealthcare conducts this quality review by investigating the complaint and consulting with your Participating Medical Group, treating Providers and other

UnitedHealthcare internal departments. Medical records are requested and reviewed as necessary, and as such, you may need to sign an authorization to release your medical records. We will respond to your complaint in a manner, appropriate to the clinical urgency of your situation. You will also receive written notification regarding the disposition of your quality of clinical care and/or quality of service review complaint within 30 calendar days of UnitedHealthcare's receipt of your complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan

If you believe that your Health Plan enrollment or subscription has been, or will be improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

First, file your complaint with UnitedHealthcare

- You can file a complaint with UnitedHealthcare by calling our Customer Service department at 1-877-359-3714or visiting www.uhc.com/calpers.
- You should file your complaint as soon as possible after you receive notice that your Health Plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent, UnitedHealthcare must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, UnitedHealthcare must give you a decision within 30 days.

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

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

- You are not satisfied with UnitedHealthcare's decision about your complaint, or;
- You have not received the decision within 30 days, or within 3 days if the problem is urgent.
- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with UnitedHealthcare, if the DMHC determines that your problem requires immediate review.

For Help:

Contact the DMHC Help Center at the toll-free telephone number **(1-888-HMO-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.hmohelp.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).**

The Appeals Process

You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department. UnitedHealthcare's Health Services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of UnitedHealthcare's receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, UnitedHealthcare's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was

based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the *Combined Evidence of Coverage and Disclosure Form* that exclude that coverage.

Patient Protection and Affordable Care Act (PPACA) – Changes provided for under the PPACA may impact how appeals are handled and are applicable to your Health Plan.

- An Adverse Benefit Determination includes a decision to rescind coverage. You may submit an appeal for a rescission of coverage determination or a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department.
- You may submit an appeal for any Adverse Benefit Determination as defined in Section 10. Definitions.
- If any new or additional evidence is relied upon or generated by UnitedHealthcare or the Participating Medical Group during the determination of an appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

In addition, you may request a review by the California Department of Managed Care (DMHC) Director if you believe your policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the DMHC Help Center at the toll-free telephone number **(1-888-HMO-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.hmohelp.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).**

Expedited Review Appeals Process

Appeals involving an imminent and serious threat to your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to UnitedHealthcare's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, UnitedHealthcare will immediately inform you of your review status and your right to notify the Department of Managed Health Care (DMHC) of the Grievance.

You and the DMHC will be provided a written statement of the disposition or pending status of the expedited review no later than three calendar days from receipt of the Grievance. You are not required to participate in the UnitedHealthcare appeals process prior to contracting the DMHC regarding your expedited appeal.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with UnitedHealthcare's Appeal Process determination, you can request that UnitedHealthcare submit the appeal to voluntary mediation or binding arbitration before JAMS.

Voluntary Mediation

In order to initiate voluntary mediation, either you or the agent acting on your behalf must submit a written request to UnitedHealthcare. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The

Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

Experimental or Investigational Treatment

A UnitedHealthcare medical director may deny a treatment if he or she determines it is Experimental or Investigational, except as described in "Cancer Clinical Trials" under **Section 5. Your Medical Benefits**. If you have a Terminal Illness, as defined below, you may request that UnitedHealthcare hold a conference within 30 calendar days of receiving your request to review the denial. For purposes of this paragraph, Terminal Illness means an incurable or irreversible condition that has a high probability of causing death within one year or less. The conference will be held within five days if the treating Physician determines, in consultation with the UnitedHealthcare Medical Director and based on professionally recognized standards of practice, that the effectiveness of the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Independent Medical Review (IMR)

If you believe that a health care service included in your coverage has been improperly denied, modified or delayed by UnitedHealthcare or one of its Participating Providers, you may request an independent medical review (IMR) of the decision. IMR is available for denials, delays or modifications of health care services requested by you or your Provider based on a finding that the requested service is Experimental or Investigational or is not Medically Necessary. Your case also must meet the statutory eligibility criteria and procedural requirements discussed below. If your Complaint or appeal pertains to a Disputed Health Care Service subject to Independent Medical Review (as discussed below), you must file your Complaint or appeal within 180 calendar days of receiving a denial notice.

Eligibility for Independent Medical Review

Experimental or Investigational Treatment Decisions

If you suffer from a Life-Threatening or Seriously Debilitating condition, you may have the opportunity to seek IMR of UnitedHealthcare's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. "Life-Threatening" means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (b) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival. "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.

A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Physician certifies that you have a Life-Threatening or Seriously Debilitating condition for which:

- Standard therapies have not been effective in improving your condition; or
- Standard therapies would not be medically appropriate for you; or
- There is no more beneficial standard therapy covered by UnitedHealthcare than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.

2. Either (a) your UnitedHealthcare Participating Physician has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Physician in certifying his or her recommendation; or (b) you or your non-contracting Physician – who is a licensed, board-certified or board-eligible Physician qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Physician certification must include a statement detailing the evidence relied upon by the Physician in certifying his or her recommendation. (**Please note** that UnitedHealthcare is not responsible for the payment of services rendered by non-contracting Physicians who are not otherwise covered under your UnitedHealthcare benefits).
3. A UnitedHealthcare Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for UnitedHealthcare's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and UnitedHealthcare denies your request for Experimental or Investigational therapy, UnitedHealthcare will send a written notice of the denial within five business days of the decision. The notice will advise you of your right to request IMR, and include a Physician certification form and an application form with a preaddressed envelope to be used to request IMR from the DMHC.

Dispute Resolution

Medical Grievance Procedures

You, an authorized representative, or a provider on behalf of you, may request a grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD), which must be submitted in one of the following ways:

- Call Customer Service at 1-877-359-3714; or
- Fill out a Member Grievance Form on the UnitedHealthcare website at www.uhc.com/calpers; or
- In writing by sending information to:

  Appeals & Grievances
  UnitedHealthcare
  P.O. Box 6107
  Mail Stop CA124-0160
  Cypress, CA 90630-9972

The grievance must clearly state the issue, such as the reasons for disagreement with the ABD or dissatisfaction with the Services received. Include the identification number listed on the UnitedHealthcare Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the

Medical Necessity of the Service. If you would like us to consider your grievance on an urgent basis, please write “urgent” on your request and provide your rationale.

Behavioral Health Grievance Procedures

If your grievance involves Mental Health or Substance Abuse Services call U.S. Behavioral Health Plan, California (USBHPC) at 1-800-999-9585, or write to:
U.S. Behavioral Health Plan, California
Attn.: Appeals Department
P.O. Box 2839
San Francisco, CA 94126

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

USBHPC will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information.

To make a request, contact Customer Service at 1-800-999-9585.

If USBHPC upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the Independent External Review process described below;
- For FABDs involving benefit, you may pursue the Department of Managed Health Care’s process as described in the Department of Managed Health Care section. [or you may initiate voluntary mediation, or binding arbitration, as described in the Voluntary Mediation and Binding Arbitration section.]

Urgent Decision

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if UnitedHealthcare determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If UnitedHealthcare determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR, at 1-888-HMO-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

Experimental or Investigational Denials

UnitedHealthcare does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if UnitedHealthcare denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of UnitedHealthcare's decision from the DMHC. ***Note***: DMHC does not require you to exhaust UnitedHealthcare's appeal process before requesting an IMR of ABD's based on Experimental or Investigational Services. In such cases, you may immediately contact DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form by calling us at 1-877-359-3714 or write to us at UnitedHealthcare, P.O. Box 6107, Cypress, CA 90630. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- Your Provider must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this *plan* that is more beneficial than the proposed treatment.
- The proposed treatment must either be:
  - Recommended by a/an UnitedHealthcare *provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - Requested by you or by a licensed board certified or board eligible *doctor* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
    - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
    - Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

- Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *doctor*. Any newly developed or discovered relevant medical records that we or a UnitedHealthcare *provider* identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your *doctor* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Independent Medical Review (IMR) Involving a Disputed Health Care Service

You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your UnitedHealth Plan have been improperly denied, modified or delayed, in whole or in part, by UnitedHealthcare or one of its providers because the service is deemed not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review.

You have the right to provide information in support of the request for an IMR. UnitedHealthcare must provide you with an IMR application form and UnitedHealthcare's FABD letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against UnitedHealthcare regarding the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:

(a) Your provider has recommended a health care service as *medically necessary*, or

(b) You have had *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

(c) You have been seen by a UnitedHealthcare *provider* for the diagnosis or treatment of the medical condition for which you want an IMR;

2. The disputed health care service has been denied, changed, or delayed by us or your *medical group*, based in whole or in part on a decision that the health care service is deemed not *medically necessary*; **and**

3. You have filed a complaint with us or your *medical group* and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of UnitedHealthcare. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor UnitedHealthcare will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance Procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds UnitedHealthcare's FABD, you may have additional review rights under the CalPERS Administrative Review section.

For more information regarding the IMR process or to request an application form, please call Customer Service at 1-877-359-3714.

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 toll free at 1-877-359-3714 (TTY users call 1-855-479-3660) 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 an appeal involving an emergency, an appeal that has not been satisfactorily resolved by your health plan, or an appeal that has remained unresolved for more than 30 days, you may call DMHC for assistance.

You may also be eligible for an IMR. If you are eligible for an 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. DMHC also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. DMHC's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and online instructions.

In the event that UnitedHealthcare should cancel or refuse to renew enrollment for you or your dependents and you feel that such action was due to health or utilization of benefits, you or your dependents may request a review by the DMHC Director.

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections, Grievance Procedures, Experimental or Investigational Denials, Independent Medical Review **(IMR)** Involving a Disputed Health Care Service, and Department of Managed Health Care, you have additional dispute resolution options, as follows below:

1. Eligibility issues

Issues of eligibility must be referred directly to CalPERS at:
CalPERS Member Account Management Division
Attn: Enrollment Administration
P.O. Box 942714
Sacramento, CA 94229-2714

888 CalPERS (or **888-**225-7377) CalPERS Customer Service and Outreach Division toll free telephone number
1-916-795-1277 fax number

2. Coverage Issues

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this EOC booklet. It does not include a plan or contracting provider decision regarding a Disputed Health Care Service.

If you are dissatisfied with the outcome of UnitedHealthcare's internal appeal process or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court, *[or initiate voluntary mediation or binding arbitration]*. If you initiate voluntary mediation and are not successful in resolving your dispute, you may request review by the DMHC. Upon exhaustion of the DMHC review process, you may then request a CalPERS Administrative Review. You may **not** request a CalPERS Administrative Review if you decide to proceed to court, *or initiate binding arbitration.*

3. Malpractice and Bad Faith

You must proceed directly to court.

4. Disputed Health Care Service Issue

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not medically necessary, or Experimental or Investigational.
If you are dissatisfied with the outcome of UnitedHealthcare's internal grievance process or if you have been in the process for 30 days or more, you may request an IMR from the DMHC.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to court. If you choose to proceed to court, you may **not** request a CalPERS Administrative Review.

Voluntary Mediation and Binding Arbitration
If you are dissatisfied with UnitedHealthcare's Appeal Process determination, you can request that UnitedHealthcare submit the appeal to voluntary mediation or binding arbitration before JAMS.

Voluntary Mediation
In order to initiate voluntary mediation, either you or the agent acting on your behalf must submit a written request to UnitedHealthcare. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

CalPERS Administrative Review

If you remain dissatisfied with the DMHC's determination or the IMR's determination, you may request an Administrative Review. You must exhaust UnitedHealthcare's internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC's determination or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination.

The request must be mailed to:
CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information UnitedHealthcare may have regarding your dispute with your request for Administrative Review, please note that UnitedHealthcare may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after UnitedHealthcare submits the information it has regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if you request an IMR at the same time you submit a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue a determination until the IMR determination is issued.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to your case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board’s final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

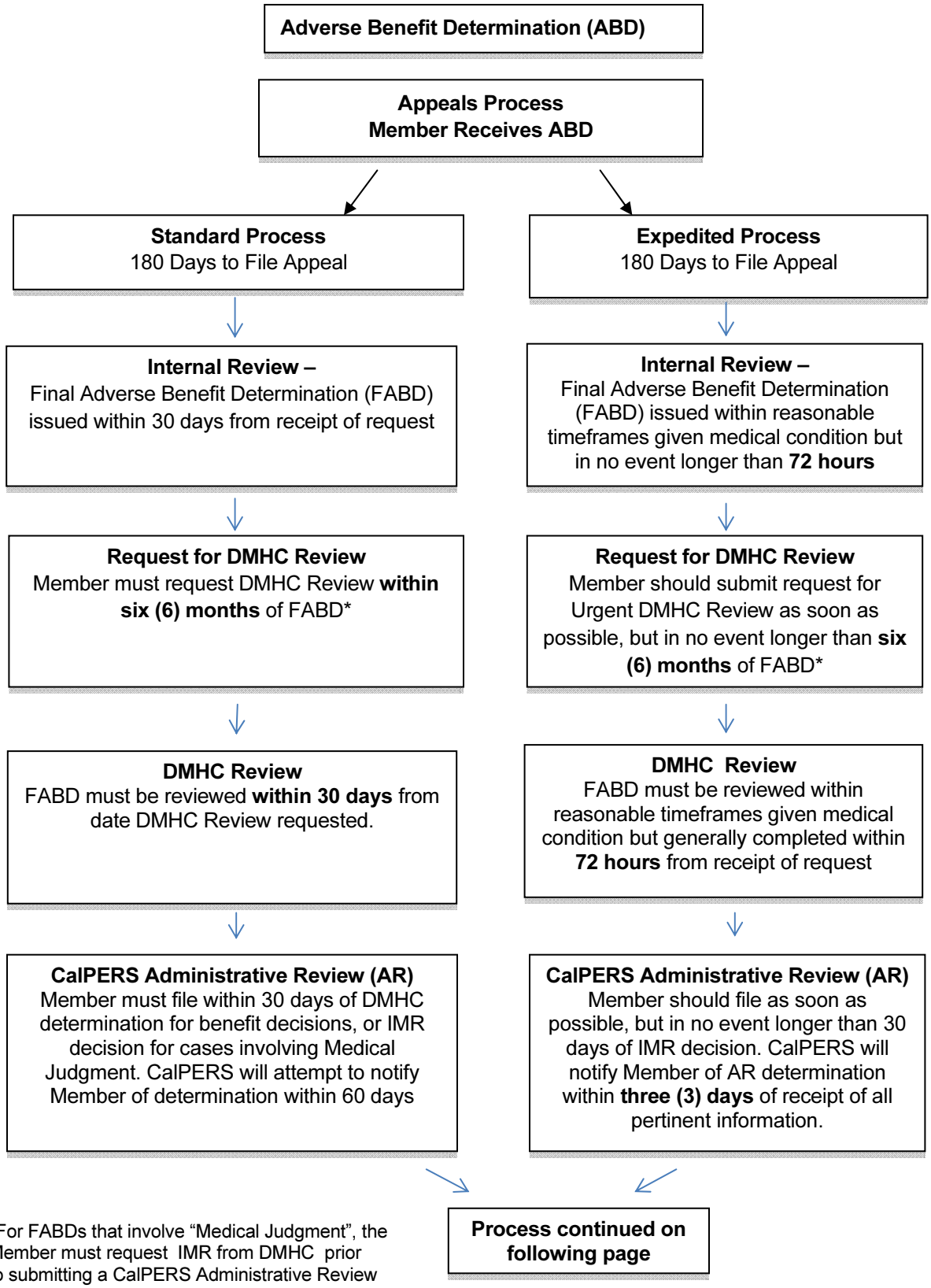
If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

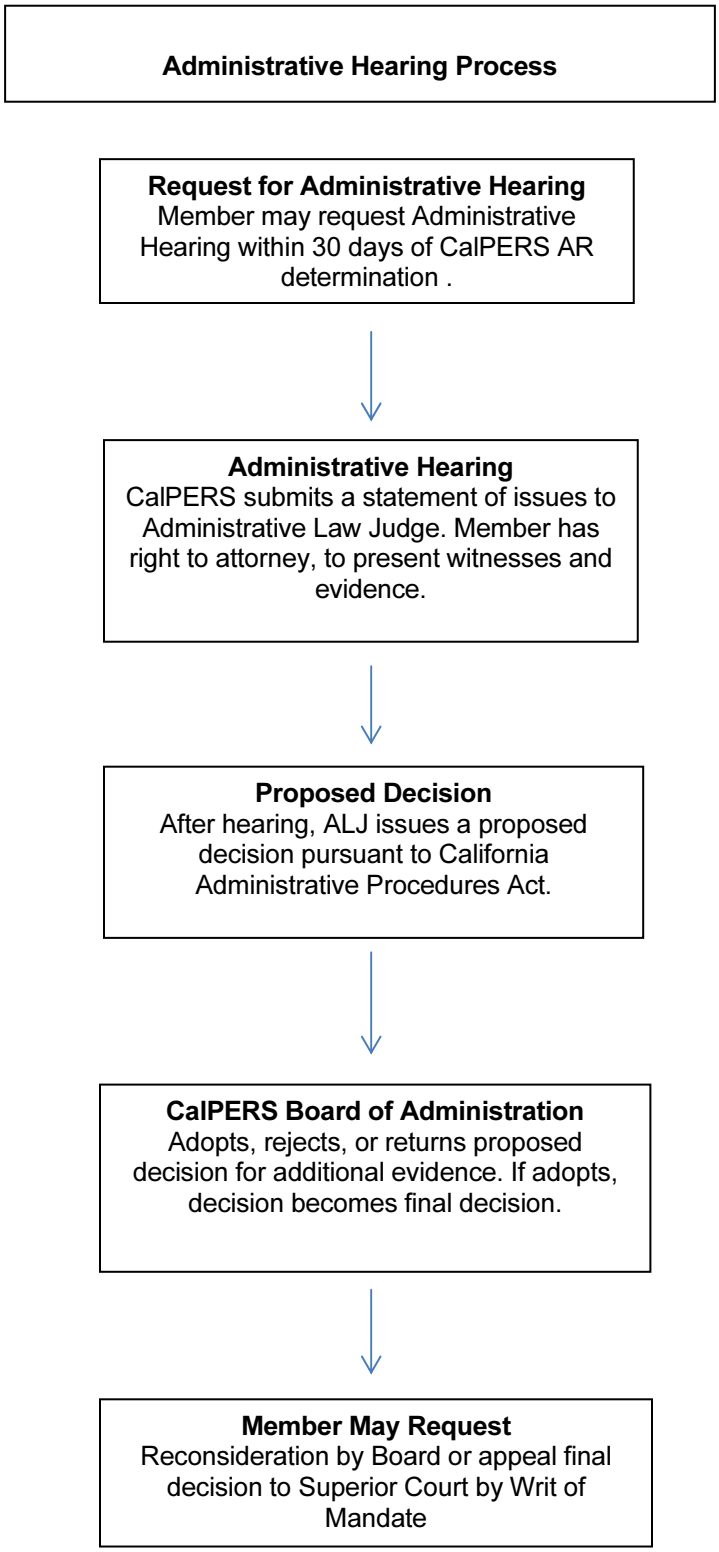
Summary of Process and Rights of Members under the Administrative Procedure Act

- Right to records, generally. You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- Records subject to attorney-client privilege. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- Attorney Representation. At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- Right to experts and consultants. At any stage of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.

APPEAL CHART



*For FABDs that involve "Medical Judgment", the Member must request IMR from DMHC prior to submitting a CalPERS Administrative Review


Administrative Hearing Process
Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of CalPERS AR determination .
Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.
Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.
CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence. If adopts, decision becomes final decision.
Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Definitions

Adverse Benefit Determination (ABD) - a decision by UnitedHealthcare to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this UnitedHealthcare plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an adverse benefit determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Authorized Representative – means an individual designated by you to receive Protected Health Information about you for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by you in writing on a form approved by UnitedHealthcare.

Disputed Health Care Service – any Health Care Service eligible for coverage and payment under your UnitedHealthcare Plan that has been denied, modified or delayed by UnitedHealthcare or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Life-Threatening Condition – having a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

Seriously Debilitating Condition – having a disease or condition that could cause major irreversible morbidity.

Dispute Resolution

Behavioral Health Grievance Procedures
If your grievance involves Mental Health or Substance Abuse Services call U.S. Behavioral Health Plan, California (USBHPC) at 1-800-999-9585, or write to:

U.S. Behavioral Health Plan, California
Attn.: Appeals Department
P.O. Box 2839
San Francisco, CA 94126

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

USBHPC will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information. To make a request, contact Customer Service at 1-800-999-9585.

If USBHPC upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the Independent External Review process described below;
- For FABDs involving benefit, you may pursue the Department of Managed Health Care's process as described in the Department of Managed Health Care section. [or you may initiate voluntary mediation, or binding arbitration, as described in the Voluntary Mediation and Binding Arbitration section.]

Urgent Decision

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if USBHPC determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If USBHPC determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR, at 1-888-HMO-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

Experimental or Investigational Denials

USBHPC does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if USBHPC denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of USBHPC's decision from the DMHC. ***Note***: DMHC does not require you to exhaust USBHPC's appeal process before requesting an IMR of ABD's based on Experimental or Investigational Services. In such cases, you may immediately contact DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form by

calling us at 1-800-999-9585 or write to us at U.S. Behavioral Health Plan, California, P.O. Box 2839, San Francisco, CA 94126. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- Your Provider must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this *plan* that is more beneficial than the proposed treatment.
- The proposed treatment must either be:
  - Recommended by a/an USBHPC *provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - Requested by you or by a licensed board certified or board eligible *doctor* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
    - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
    - Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
    - Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
    - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
    - Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.
You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *doctor*. Any newly developed or discovered relevant medical records that we or a USBHPC *provider* identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your *doctor* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your UnitedHealth Plan have been improperly denied, modified or delayed, in whole or in part, by USBHPC or one of its providers because the service is deemed not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review.

You have the right to provide information in support of the request for an IMR. USBHPC must provide you with an IMR application form and USBHPC's FABD letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against USBHPC regarding the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:
   (a) Your provider has recommended a health care service as *medically necessary*, or
   (b) You have had *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
   (c) You have been seen by a USBHPC *provider* for the diagnosis or treatment of the medical condition for which you want an IMR;
2. The disputed health care service has been denied, changed, or delayed by us or your *medical group*, based in whole or in part on a decision that the health care service is deemed not *medically necessary*; **and**
3. You have filed a complaint with us or your *medical group* and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

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If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of USBHPC. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor USBHPC will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance Procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds USBHPC's FABD, you may have additional review rights under the CalPERS Administrative Review section.

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If you have a grievance against your health plan, you should first telephone your health plan toll free at 1-877-359-3714 (TTY users call 1-855-479-3660) 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 an appeal involving an emergency, an appeal that has not been satisfactorily resolved by your health plan, or an appeal that has remained unresolved for more than 30 days, you may call DMHC for assistance.

You may also be eligible for an IMR. If you are eligible for an 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. DMHC also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. DMHC's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and online instructions.

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P.O. Box 942714
Sacramento, CA 94229-2714

888 CalPERS (or **888-**225-7377) CalPERS Customer Service and Outreach Division toll free telephone number
1-916-795-1277 fax number

2. Coverage Issues

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this EOC booklet. It does not include a plan or contracting provider decision regarding a Disputed Health Care Service.

If you are dissatisfied with the outcome of USBHPC's internal appeal process or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court, *[or initiate voluntary mediation or binding arbitration]*. If you initiate voluntary mediation and are not successful in resolving your dispute, you may request review by the DMHC. Upon exhaustion of the DMHC review process, you may then request a CalPERS Administrative Review. You may **not** request a CalPERS Administrative Review if you decide to proceed to court, *or initiate binding arbitration.*

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4. Disputed Health Care Service Issue

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not medically necessary, or Experimental or Investigational.

If you are dissatisfied with the outcome of USBHPC's internal grievance process or if you have been in the process for 30 days or more, you may request an IMR from the DMHC.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to court. If you

choose to proceed to court, you may **not** request a CalPERS Administrative Review.

Voluntary Mediation and Binding Arbitration
If you are dissatisfied with USBHPC's Appeal Process determination, you can request that USBHPC 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 USBHPC. 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.

CalPERS Administrative Review

If you remain dissatisfied with the DMHC's determination or the IMR's determination, you may request an Administrative Review. You must exhaust USBHPC's internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC's determination or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information USBHPC may have regarding your dispute with your request for Administrative Review, please note that USBHPC may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after USBHPC submits the information it has regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service

disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if you request an IMR at the same time you submit a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue a determination until the IMR determination is issued.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to your case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

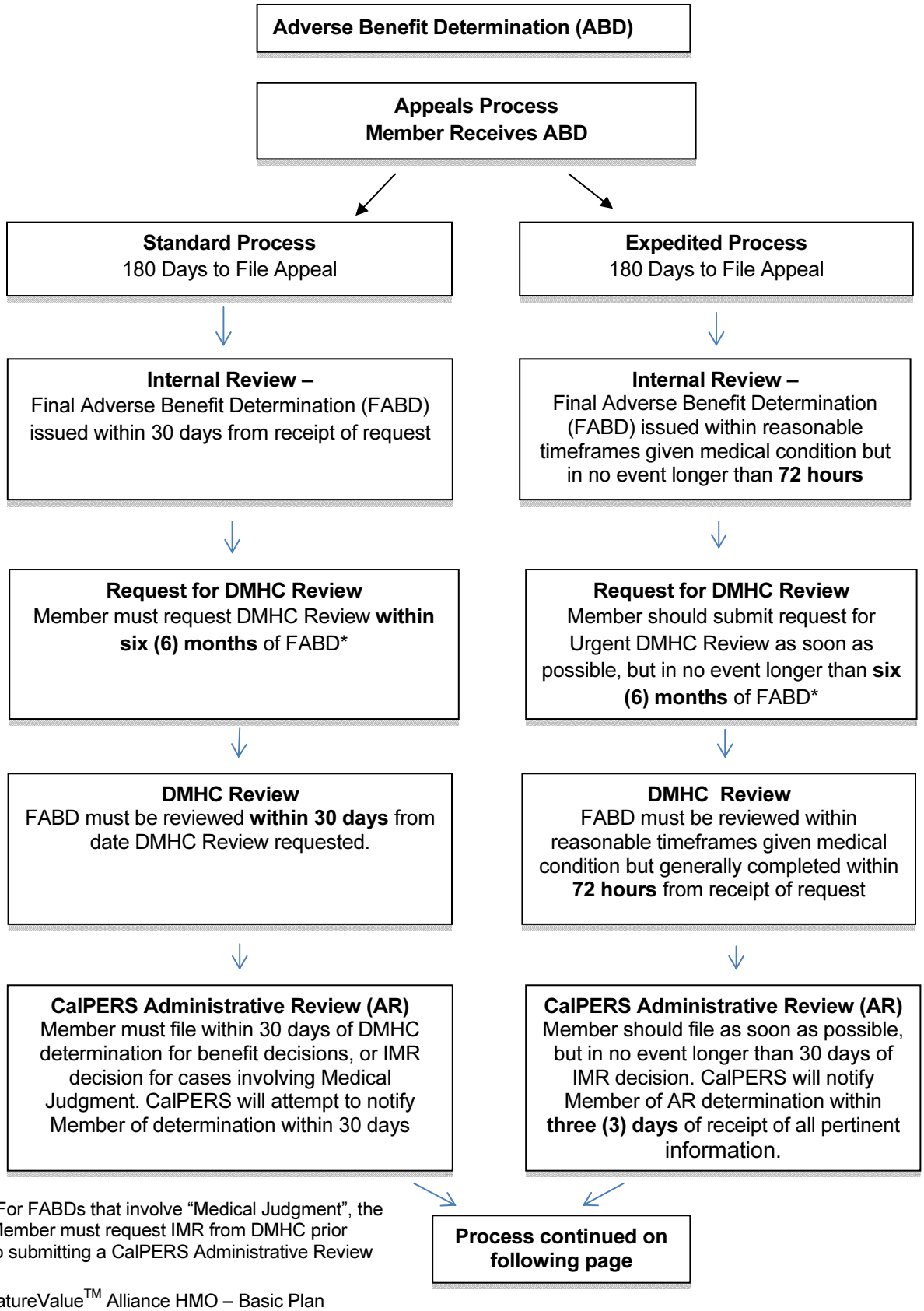
If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

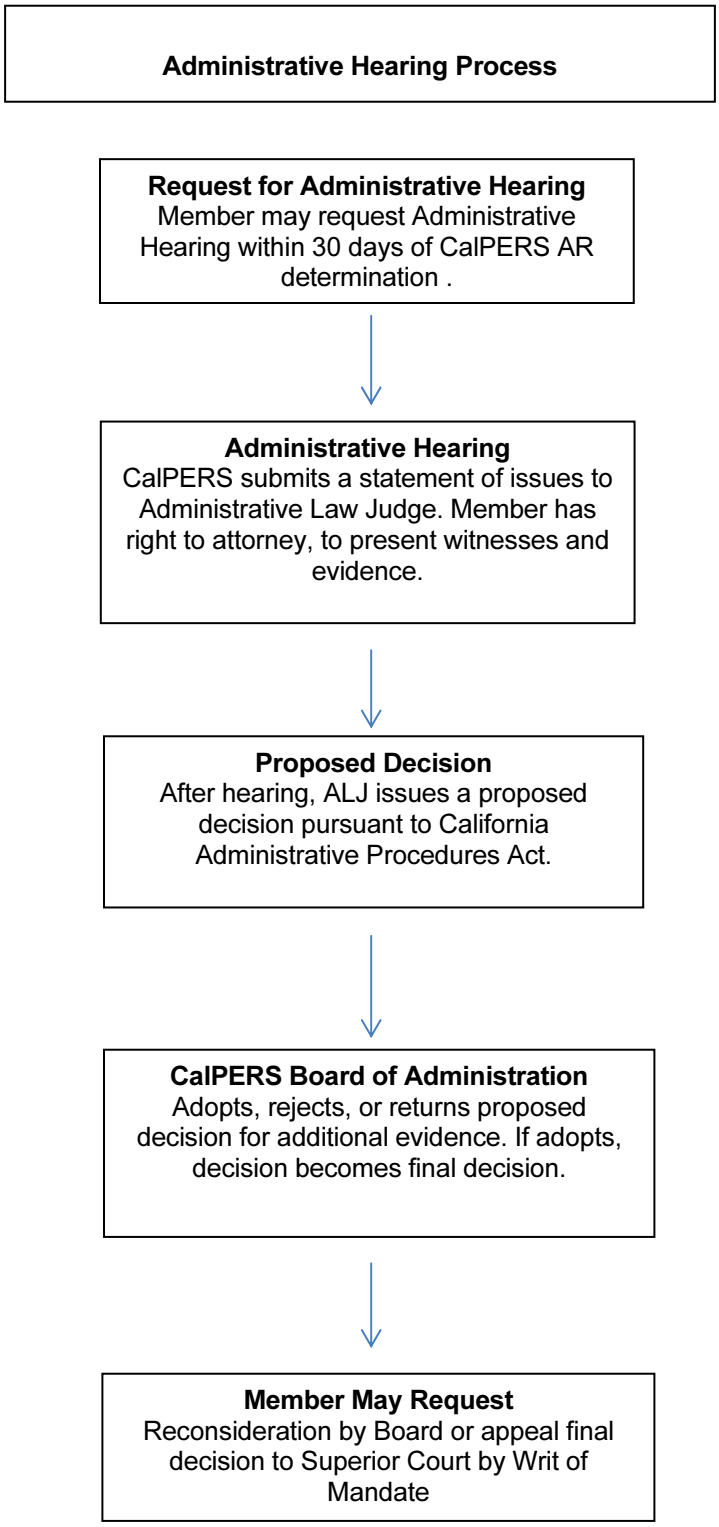
Summary of Process and Rights of Members under the Administrative Procedure Act

- Right to records, generally. You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- Records subject to attorney-client privilege. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- Attorney Representation. At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- Right to experts and consultants. At any stage of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.

APPEAL CHART



*For FABDs that involve "Medical Judgment", the Member must request IMR from DMHC prior to submitting a CalPERS Administrative Review


Administrative Hearing Process
Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of CalPERS AR determination .
Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.
Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.
CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence. If adopts, decision becomes final decision.
Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Definitions

Adverse Benefit Determination (ABD) - a decision by USBHPC to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this USBHPC plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an adverse benefit determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Authorized Representative - means an individual designated by you to receive Protected Health Information about you for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by you in writing on a form approved by USBHPC.

Disputed Health Care Service - any Health Care Service eligible for coverage and payment under your USBHPC Plan that has been denied, modified or delayed by USBHPC or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Life-Threatening Condition – having a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

Seriously Debilitating Condition – having a disease or condition that could cause major irreversible morbidity

Disputed Health Care Services

You may also request Independent Medical Review (IMR) of a Disputed Health Care Service. A Disputed Health Care Service is any health care service eligible for coverage and payment under your Health Plan that has been denied, modified or delayed by UnitedHealthcare or one of its Participating Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (**Note:** Disputed Health Care Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny health care services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your health care coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Health Care Service if you meet all of the following criteria:

1. (a) Your Provider has recommended a health care service as Medically Necessary; or (b) you have received Urgently Needed Services or Emergency Services that a Provider determined were Medically Necessary; or (c) you have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The health care service has been denied, modified or delayed by UnitedHealthcare or one of its Participating Providers; and
3. You have filed an appeal with UnitedHealthcare regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the appeal remains unresolved after 30 days (or three days in the case of an urgent appeal requiring expedited review). (Note: If there is an imminent and serious threat to your health, the DMHC may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 calendar days if the DMHC determines that an earlier review is necessary in extraordinary and compelling cases if the DMHC finds that you have acted reasonably.)

You may apply to the DMHC for IMR of a Disputed Health Care Service within six months of any of the events or periods described above, or longer if the DMHC determines that the circumstances of your case warrant an IMR review. UnitedHealthcare will provide you an IMR application form with any Grievance disposition letter that denies, modifies or delays health care services based in whole or in part due to a finding that the service is not Medically Necessary. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against UnitedHealthcare regarding the Disputed Health Care Service. The IMR process is in addition to any other procedures or remedies that may be available to you.

Independent Medical Review (IMR) Procedures

Applying for Independent Medical Review Procedures

In the case of Experimental or Investigational coverage decisions, if you have a Life-Threatening or Seriously Debilitating condition, UnitedHealthcare will include an application for IMR in its notice to you that the requested service has been denied and include a Physician certification form with a preaddressed envelope to the DMHC. Your Physician must provide the Physician certification and medical and scientific documentation required for Experimental and Investigational IMR, which may be included with your application, or mailed or faxed directly to the DMHC by your Physician. Either you or your Physician can provide the letter from UnitedHealthcare or its Participating Provider denying the request for Experimental or Investigational treatment.

In the case of determinations that a Disputed Health Care Service is not Medically Necessary, UnitedHealthcare will provide you with an IMR application form with any disposition letter resolving your appeal of the determination. Your application for IMR of a Disputed Health Care Service may include information or documentation regarding a Provider's recommendation that the service is Medically Necessary, medical information that a service received on an urgent care or emergency basis was Medically Necessary, and any

other information you received from or gave to UnitedHealthcare or its Participating Providers that you believe is relevant in support of your position that the Disputed Health Care Service was Medically Necessary.

Completed applications for IMR should be submitted to the DMHC. You pay no fee to apply for IMR. You, your Physician, or another designated representative acting on your behalf may request IMR. If there is any additional information or evidence you or your Physician wish to submit to the DMHC that was not previously provided to UnitedHealthcare, you may include this information with the application for IMR. The DMHC fax number is (916) 229-0465. You may also reach the DMHC by calling 1-888-HMO-2219.

Accepted Applications for Independent Medical Review

Upon receiving your application for IMR, the DMHC will review your request and notify you whether your case has been accepted. If your case is eligible for IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of UnitedHealthcare, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor UnitedHealthcare will control the choice of expert reviewers.

UnitedHealthcare must provide the following documents to the IRO within three business days of receiving notice from the DMHC that you have successfully applied for an IMR:

1. The relevant medical records in the possession of UnitedHealthcare or its Participating Providers;
2. All information provided to you by UnitedHealthcare and any of its Participating Providers concerning UnitedHealthcare and Provider decisions regarding your condition and care (including a copy of UnitedHealthcare's denial notice sent to you);
3. Any materials that you or your Provider submitted to UnitedHealthcare and its Participating Providers in support of the request for the health care services;
4. Any other relevant documents or information used by UnitedHealthcare or its Participating Providers in determining whether the health care service should have been provided and any statement by UnitedHealthcare or its Participating Providers explaining the reasons for the decision. The Plan shall provide copies of these documents to you and your Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to your health, UnitedHealthcare will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required material to the IRO, UnitedHealthcare will promptly issue you a notification that includes an annotated list of the documents submitted and offer you the opportunity to request copies of those documents from UnitedHealthcare.

If there is any information or evidence you or your Provider wish to submit to the DMHC in support of IMR that was not previously provided to UnitedHealthcare, you may include this information with your application to the DMHC. Also as required, you or your Provider must provide to the DMHC or the IRO copies of any relevant medical records, and any newly developed or discovered relevant medical records after the initial documents are provided, and respond to any requests for additional medical records or other relevant information from the expert reviewers.

The Independent Medical Review (IMR) Decision

The independent review panel will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical, within 30 calendar days of receiving your request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of an Experimental or Investigational determination, if your Physician determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this

instance, the analysis and recommendations will be rendered within seven calendar days of the request for expedited review. The review period can be extended up to three calendar days for a delay in providing required documents at the request of the expert. The organization shall complete its review and make its determination in writing and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director.

- If the disputed health care service has not been provided and the enrollee's Provider or the Department certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.
- Subject to the approval of the DMHC, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, UnitedHealthcare, you and your Physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by UnitedHealthcare, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the experts' recommendation. In the case of a review of a Disputed Health Care Service denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewers' relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the health care service should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the health care service, UnitedHealthcare will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on UnitedHealthcare. UnitedHealthcare will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, UnitedHealthcare will reimburse either you or your Provider – whichever applies – within five business days. In the case of services not yet rendered to you, UnitedHealthcare will authorize the services within five business days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of your medical condition, and will inform you and your Physician of the authorization.

UnitedHealthcare will promptly reimburse you for reasonable costs associated with Urgently Needed Services or Emergency Services outside of UnitedHealthcare's Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds your decision to secure services outside of UnitedHealthcare's Participating Provider network prior to completing the UnitedHealthcare Grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the Disputed Health Care Services were a covered benefit under the UnitedHealthcare Subscriber contract.

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

For more information regarding the IMR process, or to request an application, please call UnitedHealthcare's Customer Service department.

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 **1-877-359-3714 or 711 (TTY)** and use your Health Plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your Health Plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDHI line **(1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet website **http://www.hmohelp.ca.gov** has Complaint forms, IMR application forms and instructions online.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

Claims against a Participating Medical Group, the group's Physicians, or Providers, Physicians or Hospitals – other than claims for benefits under your coverage – are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Participating Medical Group (or one of its Participating Providers) for claims not involving benefits, UnitedHealthcare agrees to make available the Member appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties The Grievance will not be subject to binding arbitration except upon agreement between the parties. Should the parties fail to resolve the Grievance, you or the Participating Medical Group (or its Participating Provider) may seek any appropriate legal action deemed necessary. Member claims against UnitedHealthcare will be handled as discussed above under "Appealing a Health Care Decision or Requesting a Quality of Care Review."

Appeal Procedure Following Disposition of Plan Grievance or Appeal Process

If no resolution of your complaint is reached by the internal grievance or appeal process described in the previous sections, you have several options depending on the nature of your complaint.

1. **Eligibility Issues.** Refer these matters directly to CalPERS at the following:

   CalPERS
   Attn: Member Account Management Division
   P.O. Box 942714
   Sacramento, CA 4229-2714
   OR telephone CalPERS Customer Service and Outreach Division at **888 CalPERS** (or 888-225-7377), TTY 1-800-735-2929; (916) 795-3240.

2. **Coverage Issues.** A coverage issue concerns the denial or approval of health care or behavioral health services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage booklet. It does not include a plan or contracting provider decision regarding a disputed health care or behavioral health service.

If you are dissatisfied with the outcome of UnitedHealthcare's internal complaint process or if you have been in the process for 30 days or more, you may request review by the Department of Managed Health Care (DMHC), proceed to court or Binding Arbitration (as described in the previous section), if your coverage dispute is within the jurisdictional limits of Small Claims Court, or request an Administrative Review by CalPERS. If you choose to proceed to court or Binding Arbitration, you may not request an Administrative Review by CalPERS.

3. **Malpractice.** You must proceed directly to court.

4. **Bad Faith.** You must proceed directly to court.

5. **Disputed Health Care or Service Issue.** A disputed health care or behavioral health service issue concerns any health care or behavioral health service eligible for coverage and payment under this Evidence of Coverage booklet that has been denied, modified, or delayed in whole or in part due to a finding that the services are not medically necessary. A decision regarding a disputed health care or behavioral health service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is experimental or investigational.

   If you are dissatisfied with the outcome of UnitedHealthcare's internal complaint process or if you have been in the process for 30 days or more, you may request an external independent medical review from the Department of Managed Health Care (DMHC) as explained under "Eligibility for Independent Medical Review, Disputed Health Care or Behavioral Health Services" sections above.

   If you are dissatisfied with the outcome of UnitedHealthcare's internal complaint process or the external independent medical review process, you may request an Administrative Review by CalPERS, or you may proceed to court. If you choose to proceed to court or Binding Arbitration, you may not request an Administrative Review by CalPERS.

CalPERS Administrative Review and Hearing Process

Administrative Review

Issues of eligibility, coverage issues which concern the denial or approval of health care or behavioral health services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage booklet and disputed health care or behavioral health issues may be appealed directly to CalPERS through its Administrative Review process only after exhaustion of UnitedHealthcare's internal appeal or , if applicable, the Independent Medical Review process through DMHC.

You may request an Administrative Review if you are dissatisfied with the outcome of UnitedHealthcare's internal complaint process, the outcome of the review of a grievance by the Department of Managed Health Care (DMHC) or the outcome of a request for or decision from the external independent medical review process. In addition, you may request an Administrative Review if you have been in UnitedHealthcare's internal complaint process for 30 days or more. All requests for Administrative Review must be submitted to CalPERS, in writing, within 30 days of the postmark date of UnitedHealthcare's letter of denial, the DMHC's determination of findings or the written decision from the Director of the DMHC informing you of the outcome of the external independent medical review process or a denial of a request for the external independent medical review process. A request for Administrative Review when you have been participating in UnitedHealthcare's internal grievance process for 30 days or more can be submitted as soon as the 30 days have elapsed and must be in writing as well.

To file for an Administrative Review, contact:

CalPERS Health Plan Administrative Division
Attn: Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953
Fax: (916) 795-1513

OR telephone CalPERS Customer Service and Outreach Division at **888 CalPERS** (or 888-225-7377), TTY 1-800-735-2929; (916) 795-3240.

You are encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to UnitedHealthcare to provide medical documentation to CalPERS. If you would like to designate an Authorized Representative to represent him/her in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. You must complete and sign the form. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding your request for Administrative Review. If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send copies of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination of its Administrative Review within 60days from the date all pertinent information is received by CalPERS. For issues needing an expedited decision, CalPERS will make a determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours from the time of the request.

Note: In urgent situations, if you request an external independent medical review from the DMHC before, at the same time, or after you make a request for CalPERS Administrative Review, but before a determination has been made, CalPERS will not issue its determination until the external independent medical review decision is issued.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

You must file for Administrative Hearing within 30 days of the date of the Administrative Review determination, or within 30 days of the external independent medical review decision of you elected the external independent medical review process from the Department of Managed Health Care (DMHC) after an Administrative Review determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file an appeal, not to exceed 30 days.

The appeal must set forth the facts and the law upon which the appeal is based. The Administrative Hearing is conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.), and is a formal legal proceeding held before an Administrative Law Judge (ALJ). You may, but are not required, to be represented by an attorney. If unrepresented, you should become familiar with this law and its requirements. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open meeting. The Board's final decision will be provided in writing to you within two weeks of the Hearing.

Appeal Beyond Administrative Review and Administrative Hearing

If you are dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from UnitedHealthcare and/or CalPERS, as applicable.

- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any state of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor UnitedHealthcare will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants.** At any state of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor UnitedHealthcare will reimburse you for the costs of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 “Q” Street
Sacramento, CA 95814

SECTION 9. GENERAL INFORMATION

- **How to Replace Your Card**
- **Translation Assistance**
- **Speech- and Hearing-Impaired Assistance**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Organ and Tissue Donation**
- **Public Policy Participation**
- **Nondiscrimination Notice**

What follows are answers to some common and uncommon questions about your coverage. If you have any questions of your own that haven't been answered, please call our Customer Service department.

What should I do if I lose or misplace my membership card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does UnitedHealthcare offer a translation service?

UnitedHealthcare uses a telephone translation service for almost 140 languages and dialects. That's in addition to select Customer Service representatives who are fluent in Spanish. Translated Member materials are available upon request. Interpretation services may also be available at the Participating Provider office. Please contact the Participating 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 Participating Medical Groups and Hospitals will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or Hospital for Emergency Services. UnitedHealthcare will later provide appropriate reimbursement.

Nondiscrimination Notice

UnitedHealthcare does not exclude, deny covered benefits to, or otherwise discriminate against any Member on the ground of race, color, or national origin, or on the basis of disability or age in participation in, or receipt of the Covered Services under, any of its Health Plans, whether carried out by UnitedHealthcare directly or through a Participating Medical Group or any other entity with which UnitedHealthcare arranges to carry out Covered Services under any of its Health Plans.

This statement is in accordance 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 pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

How does UnitedHealthcare compensate its Participating Providers?

UnitedHealthcare itself is not a Provider of health care. UnitedHealthcare typically contracts with independent medical groups to provide medical services to its Members, and with Hospitals to provide Hospital Services. Once they are contracted, they become UnitedHealthcare Participating Providers.

Participating Medical Groups in turn employ or contract with individual Physicians. None of the Participating Medical Groups or Participating Hospitals, or their Physicians or employees, are employees or agents of UnitedHealthcare. Likewise, neither UnitedHealthcare nor any employee of UnitedHealthcare is an employee or agent of any Participating Medical Group, Participating Hospital or any other Participating Provider.

Most of our Participating Medical Groups receive an agreed-upon monthly payment from UnitedHealthcare to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly Premium received by UnitedHealthcare. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Participating Medical Group.

Some of UnitedHealthcare's Participating Hospitals receive similar monthly payments in return for providing Hospital Services for Members. Other Participating Hospitals are paid on a discounted fee-for-service or fixed charge per day of Hospitalization. Most acute care, Subacute and Transitional Care and Skilled Nursing Facilities are paid on a fixed charge per day basis for Inpatient care.

At the beginning of each year, UnitedHealthcare and its Participating Medical Groups agree on a budget for the cost of services for all UnitedHealthcare Members assigned to the Participating Medical Group. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Participating Medical Group shares in the savings.

The Participating Hospital and Participating Medical Group typically participate in programs for Hospital Services similar to what is described above.

Stop-loss insurance protects Participating Medical Groups and Participating Hospitals from large financial expenses for health care services. UnitedHealthcare provides stop-loss protection to our Participating Medical Groups and Participating Hospitals that receive the monthly payments described above. If any Participating Hospital or Participating Medical Group does not obtain stop-loss protection from UnitedHealthcare, it must obtain stop-loss insurance acceptable to UnitedHealthcare.

UnitedHealthcare arranges with additional Providers or their representatives for the provision of Covered Services that cannot be performed by your assigned Participating Medical Group or Participating Hospital. Such services include authorized Covered Services that require a specialist not available through your Participating Medical Group or Participating Hospital or Emergency and Urgently Needed Services. UnitedHealthcare or your Participating Medical Group pays these Providers at the lesser of the Provider's reasonable charges or agreed-to rates. Your responsibility for Covered Services received from these Providers is limited to payment of applicable Copayments. (For more about Copayments, see **Section 6. Payment Responsibility**.) You may obtain additional information on UnitedHealthcare's compensation arrangements by contacting UnitedHealthcare or your Participating Medical Group.

How do I become an organ and tissue donor?

Transplantation has helped thousands of people suffering from organ failure or in need of corneas, skin, bone or other tissue. The need for donated organs and tissues continues to outpace the supply. At any given time, nearly 50,000 Americans may be waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others.

Almost anyone can be a donor. There is no age limit and the number of donors age 50 or older has increased. If you have questions or concerns about organ donation, speak with your family, doctor or clergy. There are many resources that can provide the information you need to make a responsible decision.

If you do decide to become a donor, be sure to share your decision. Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a Family Member gives consent at the time of your death – even if you have signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

How can I learn more about being an organ and tissue donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation (**www.transweb.org**)
- Department of Health and Human Services (**www.organdonor.gov**)

Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then keep the card with you at all times where it can be easily found.

Keep in mind that even if you have signed a donor card, you must tell your family so they can act on your wishes.

How can I participate in the establishment of UnitedHealthcare's public policy participation?

UnitedHealthcare gives its Members the opportunity to participate in establishing the public policy of the Health Plan. One third of UnitedHealthcare of California's Board of Directors is comprised of Health Plan Members. If you are interested in participating in the establishment of the Health Plan's public policy, please call or write our Customer Service department.

SECTION 10. DEFINITIONS

UnitedHealthcare is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Combined Evidence of Coverage and Disclosure Form, as well as the Schedule of Benefits.

Adverse Benefit Determination – means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including the following:

- a determination of a member's eligibility to participate in the Health Plan (including rescission);
- a determination that services are not covered based on certain exclusions or limitations on otherwise Covered Services; and
- a determination that benefits are Experimental or Investigational or not Medically Necessary or appropriate.

Annual Copayment Maximum – The maximum amount of Copayments a Member is required to pay for certain Covered Services in a calendar year. (Please refer to your *Schedule of Benefits*.)

Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or Autism – professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the 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 Participating Physician licensed pursuant to the California Business and Professions Code or is developed by a licensed participating psychologist pursuant to the California Business and Professions Code or as authorized under California law.

The treatment is provided under a treatment plan prescribed by a Participating Qualified Autism Service Provider and is administered by one of the following:

- A Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Professional supervised and employed by the Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Paraprofessional supervised and employed by a Participating Qualified Autism Service Provider.

The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the Participating Qualified Autism Service Provider does all of the following:

- Describes the Member’s behavioral health impairments to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member’s progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to your *Combined Evidence of Coverage and Disclosure Form*.

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion, on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources in order to promote a quality outcome for the individual Member.

Chronic Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period – A calendar year.

Cognitive Behavioral Therapy – Psychotherapy where the emphasis is on the role of thought patterns in moods and behaviors.

Cognitive Rehabilitation Therapy – Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher level cognitive ability. This therapy is direct (one-on-one) patient contact.

Complementary and Alternative Medicine – Defined by the National Center for Complementary and Alternative Medicine as the broad range of healing philosophies (schools of thought), approaches and therapies that Conventional Medicine does not commonly use, accept, study or make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in Hospitals. These types of therapies used alone are often referred to as "alternative." When used in combination with other alternative therapies, or in addition to conventional therapies, these therapies are often referred to as "complementary."

Completion of Covered Services – Covered Services for the Continuity of Care Condition under treatment by the Terminated Provider or Non-Participating Provider will be considered complete, when (i) the Member's Continuity of Care Condition under treatment is medically/clinically stable, and (ii) there are no clinical contraindications that would prevent a medically/clinically safe transfer to a Participating Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the Terminated Provider or Non-Participating Provider, and as applicable, the Member's assigned Participating Provider.

Continuity of Care Condition(s) – The Completion of Covered Services will be provided by: (i) a Terminated Provider to a Member who, at the time of the Participating Provider's contract Termination, was receiving Covered Services from that Participating Provider, or (ii) Non-Participating Provider for a newly enrolled Member who, at the time his or her coverage became effective with UnitedHealthcare, was receiving Covered Services from the Non-Participating Provider, for one of the Continuity of Care Conditions, as limited and described below:

1. **An Acute Condition** – A medical condition, including medical and Mental Health[1], that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the Acute Condition.
2. **A Serious Chronic Condition** – A medical condition due to disease, illness, or other medical or mental health problem[2] or medical or mental health[2] 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 Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by a UnitedHealthcare Medical Director in consultation with the Member, and either (i) the Terminated Provider or (ii) the Non-Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's Termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
3. **A Pregnancy** diagnosed and documented by (i) the Terminated Provider prior to Termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with UnitedHealthcare. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** – An incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, not to exceed twelve (12) months, provided that the prognosis of death was made by the:
   (i) Terminated Provider prior to the agreement Termination date or
   (ii) Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with UnitedHealthcare.
5. **The Care of a Newborn** – Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Services will not exceed twelve (12) months from the: (i) Provider agreement Termination date, or (ii) the newly enrolled Member's effective date of coverage with UnitedHealthcare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure** – Performance of a Surgery or Other Procedure that has been authorized by UnitedHealthcare or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) Terminating Provider to occur within 180 calendar days of the agreement's Termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with UnitedHealthcare.

Conventional Medicine – Defined by the National Center for Complementary and Alternative Medicine as medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees. Other terms for Conventional Medicine are allopathic, Western, regular and mainstream medicine.

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[1] Except pursuant to the CA Health and Safety Code 1374.72, Inpatient coverage for Behavioral Health is not a covered benefit under the UnitedHealthcare HMO Commercial core coverage. Coverage for additional Behavioral Health services may be available if purchased by the Subscriber's employer as a supplemental benefit. Please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of additional coverage, if any.

[2] U.S. Behavioral Health Plan, California will coordinate Continuity of Care for Members whose employer has purchased supplemental benefits and for Members requesting continued care with a terminated or Non-Participating Provider for "Serious Mental Illnesses" and "Serious Emotional Disturbances of a Child" as defined in CA Health and Safety Code, Section 1374.72.

Copayments – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services. Copayments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

Covered Services – Medically Necessary services or supplies provided under the terms of this *Combined Evidence of Coverage and Disclosure Form*, your *Schedule of Benefits* and supplemental benefit materials.

Custodial Care – Care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a non-health care professional, the services will be considered Custodial Care.

Dependent – A Member of a Subscriber's family who is enrolled with UnitedHealthcare after meeting all of the eligibility requirements of the Subscriber's Employer Group and UnitedHealthcare and for whom applicable Health Plan Premiums have been received by UnitedHealthcare.

Designated Facility – A facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to render Covered Services for the treatment of specified diseases or conditions. The fact that a hospital is a Participating Hospital does not mean that it is a Designated Facility.

Developmental Delay – is a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and/or social development.

Developmental and Neurodevelopmental Testing – Developmental and Neurodevelopmental Testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles.

Domestic Partner is a person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Subscribers and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
  - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
  - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:

- placing the Member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;

- active labor, meaning labor at a time that either of the following would occur:
  1. there is inadequate time to effect safe transfer to another Hospital prior to delivery or
  2. a transfer poses a threat to the health and safety of the Member or unborn child.

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

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

Emergency Services – Medical screening, examination and evaluation by a Physician or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition or Psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or Psychiatric Emergency Medical Condition within the capabilities of the Facility which includes admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital for the purpose of providing care and treatment necessary to relieve or eliminate a Psychiatric Emergency Medical Condition. (For a detailed explanation of Emergency Services, see **Section 3. Emergency and Urgently Needed Services**.)

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

Enteral Feeding – Provision of nutritional requirements through a tube into the stomach or bowel. It may be administered by syringe, gravity, or pump.

Experimental or Investigational – Defined in **Section 5** under the "Exclusions and Limitations of Benefits" section of this *Combined Evidence of Coverage and Disclosure Form*.

Family Member – The Subscriber's Spouse or Domestic Partner and any person related to the Subscriber or Spouse or Domestic Partner by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with UnitedHealthcare, meets all the eligibility requirements of the Subscriber's Employer Group and UnitedHealthcare, and for whom Premiums have been received by UnitedHealthcare. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and UnitedHealthcare.

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative.

Group Agreement – The Medical and Hospital Group Subscriber Agreement entered into between UnitedHealthcare and the employer, labor union, trust, organization or association through which you enroll for coverage.

Health Plan – Your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and supplemental benefit materials.

Health Plan Premiums (or Premiums) – Amounts established by UnitedHealthcare to be paid to UnitedHealthcare by Employer on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Health Aide – A person who has completed Home Health Aide training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

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

Hospice – Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a Terminal Illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice services.

Hospitalist – A Physician whose sole practice is the management of acutely and/or chronically ill patients' health services in a Hospital setting.

Hospital Services – Services and supplies performed or supplied by a licensed Hospital on an Inpatient or Outpatient basis.

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

Infertility – Either: (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception; or (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Participating Provider as a cause of Infertility.

Intellectual Disability – An individual is determined to have an intellectual disability based on the following three criteria: Intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less).

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

Late Enrollee – An employee or employee's Dependent who declined enrollment in the UnitedHealthcare Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability – A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

Limiting Age – The age established by the Employer Group 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.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Physician and determined by the Medical Director of UnitedHealthcare or the Participating Medical Group, it is all of the following:

a. A health intervention for the purpose of treating a medical condition;

b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

   A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

i. *Treating Physician* means a Physician who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A *new intervention* is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

Medicare (Original Medicare) – The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

Medicare Eligible – Those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Member – The Subscriber or any Dependent, who is eligible, enrolled and covered by UnitedHealthcare.

Non-Participating Mental Health Providers -- A psychiatrist, psychologist or other allied behavioral health professional that is licensed, certified or as authorized under California law that has not entered into a written agreement to provide Covered Services to UnitedHealthcare's Members.

Non-Participating Providers – A Hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to UnitedHealthcare's Members.

Non-Physician Health Care Practitioners – Include, but are not limited to: Participating Qualified Autism Service Provider, Participating Qualified Autism Service Professional, Participating Qualified Autism Service Paraprofessional, acupuncturists, optometrists, podiatrists, chiropractors and nurse midwives.

Open Enrollment Period – The time period determined by UnitedHealthcare and the Subscriber's Employer Group when all Eligible Employees and their eligible Family Members may enroll in UnitedHealthcare.

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

Participating Hospital – Any general acute care Hospital licensed by the State of California that has entered into a written agreement with UnitedHealthcare to provide Hospital Services to UnitedHealthcare's Members. Participating Hospitals are independent contractors and are not employees of UnitedHealthcare.

Participating Medical Group – An independent practice association (IPA) or medical group of Physicians that has entered into a written agreement with UnitedHealthcare to provide Physician services to UnitedHealthcare's Members. An IPA contracts with independent contractor Physicians who work at different office sites. A medical group employs Physicians who typically all work at one or several physical locations. Participating Medical Groups are independent contractors and are not employees of UnitedHealthcare.

Under certain circumstances, UnitedHealthcare may also serve as the Member's Participating Medical Group. This includes, but is not limited to, when the Member's Primary Care Physician contracts directly with UnitedHealthcare and there is no Participating Medical Group.

Participating Provider – A Hospital or other health care entity, a Physician or other health care professional, or a health care vendor who has entered into a written Agreement with the network of Providers from whom the Member is entitled to receive Covered Services. Participating Providers are independent contractors and are not employees of UnitedHealthcare.

Participating Qualified Autism Service Provider – either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
- A person licensed as a Physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, or as authorized under California law, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to your *Combined Evidence of Coverage and Disclosure Form*.

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

- Provides Behavioral Health Treatment.
- Is employed and supervised by a Participating Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.

- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code or is otherwise authorized under California law.

For a description of coverage of inpatient and outpatient mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to your *Combined Evidence of Coverage and Disclosure Form*.

Participating Qualified Autism Service Paraprofessional – an unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is employed and supervised by a Participating Qualified Autism Service Provider.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.
- Has adequate education, training, and experience, as certified by a Participating Qualified Autism Service Provider.

For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to your *Combined Evidence of Coverage and Disclosure Form*.

Physician – Any licensed allopathic or osteopathic Physician.

Prevailing Rates – As determined by UnitedHealthcare, the usual, customary and reasonable rates for a particular health care service in the Service Area.

Primary Care Physician – A Participating Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services. Primary Care Physicians are independent contractors and are not employees of UnitedHealthcare.

Primary Residence – The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days, or (3) the Member is absent from the residence for more than 100 days in any six-month period.

Primary Workplace – The Facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the Hospital or Skilled Nursing Facility.

Provider – A person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Combined Evidence of Coverage and Disclosure Form* and supplemental benefit materials.

Prudent Layperson – A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

Psychiatric Emergency Medical Condition – A mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for use, food, shelter or clothing due to the mental disorder.

Psychological Testing – Psychological Testing includes the administration, interpretation and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation and other factors influencing treatment and prognosis.

Regional Organ Procurement Agency – An organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Rehabilitation Services – The individual or combined and coordinated use of medical, physical, occupational and speech therapy for developing or retraining to the maximum extent practical the functioning of individuals.

Schedule of Benefits – An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Copayment information.

Serious Emotional Disturbances of a Child – A Serious Emotional Disturbance (SED) of a Child is defined as a child who:

1. Has one or more mental disorders based upon a diagnosis in accordance with professionally recognized diagnostic criteria including but not limited to that defined by the *Diagnostic and Statistical Manual* current edition, other than a primary Substance-Related and Addictive disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms;
2. Is under the age of 18 years old; and
3. Meets one or more of the following criteria:
    a. 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:
        i. the child is at risk of removal from home or has already been removed from the home;
        ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
    b. The child displays one of the following: psychotic features, risk of suicide or risk or violence due to a mental disorder; or
    c. 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;
- Bulimia nervosa;
- Major depressive disorder;
- Obsessive-compulsive disorder;
- Panic disorder;

- Pervasive developmental disorder or autism;
- Schizoaffective disorder;
- Schizophrenia.

Service Area – A geographic region in the State of California where UnitedHealthcare is authorized by the California Department of Managed Health Care to provide Covered Services to Members.

Skilled Nursing Care – The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

Skilled Nursing Facility – A comprehensive free-standing rehabilitation Facility or a specially designed unit within a Hospital licensed by the State of California to provide Skilled Nursing Care.

Skilled Rehabilitation Care – The care provided directly by a Participating Provider or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

Spouse – The Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the State of California.

Subacute and Transitional Care – Care provided to a Member as an inpatient of a Skilled Nursing Facility that is more intensive than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

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

Substance-Related and Addictive Disorder – Alcoholism and Substance-Related and Addictive disorder that are listed in the current *Diagnostic and Statistical Manual* of the American Psychiatric Association, unless those services are specifically excluded or determined not to be Medically Necessary. The fact that a disorder is listed in the *Diagnostic and Statistical Manual* of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

Telehealth – The mode of delivering Covered Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- *Asynchronous store and forward* means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- *Distant site* means a site where a licensed health care provider who provides Covered Services is located while providing these services via a telecommunications system.
- *Originating site* means a site where a patient is located at the time Covered Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- *Synchronous interaction* means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Totally Disabled or Total Disability – For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental

impairment resulting from an injury or illness. Determination of Total Disability will be made by a Participating Medical Group Physician on the basis of a medical examination of the Member and upon concurrence by UnitedHealthcare's Medical Director.

Urgently Needed Services – Covered Services that are provided when the Member's Participating Medical Group is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the geographic area served by their Participating Medical Group. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which UnitedHealthcare is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

Utilization Review Committee – A committee used by UnitedHealthcare or a Participating Medical Group to promote the efficient use of resources and maintain the quality of health care. If necessary, this committee will review and determine whether particular services are Covered Services.

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation, when necessary, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* PROVIDES A DESCRIPTION OF THE BENEFITS AVAILABLE TO YOU UNDER YOUR UNITEDHEALTHCARE HEALTH PLAN. THE AGREEMENT BETWEEN UNITEDHEALTHCARE AND YOUR EMPLOYER CONTAINS ADDITIONAL TERMS SUCH AS PREMIUMS, LENGTH OF CONTRACT, AND GROUP TERMINATION. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT UNITEDHEALTHCARE AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE

Coverage

All benefits, including physician services, procedures, diagnostic services or medications, are covered at 50 percent of cost Copayment (based upon UnitedHealthcare's contractual rate for the services provided with the infertility provider(s)). Copayments paid for infertility treatment and infertility drugs do not apply towards your annual copayment maximum.

Exclusions

- Services not authorized and directed by the Participating Medical Group.
- Medications for the treatment of sexual dysfunction, including erectile dysfunction are covered under the Outpatient Prescription Drug Plan. Medications for the treatment of impotence, anorgasmy or hyporgasmy are excluded.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any supplies, medications, services and/or procedures used for an excluded benefit, e.g., ZIFT or IVF.
- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.
- Experimental and/or Investigational diagnostic studies or procedures, as determined by UnitedHealthcare's Medical Director or Designee.
- Advanced infertility procedures, as well as In Vitro Fertilization (IVF) and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, and ZIFT.
- Infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when infertility exists; e.g., use of another relative's sperm.
- Artificial insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
   a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
   b. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;

2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the UnitedHealthcare Medical Director or designee determines that:
   a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
   b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
   c. The Member has received the lifetime benefit maximum of six artificial insemination procedures, cumulatively, under one or more UnitedHealthcare Health Plans, has occurred.

3. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes.

UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by U.S. Behavioral Health Plan, California

Plan MTN

USBHPC Schedule of Benefits

Mental Health Services, Substance-Related and Addictive Disorder Services and Severe Mental Illness Benefits Offered by U.S. Behavioral Health Plan, California

Schedule of Benefits

Pre-Authorization is required for certain Mental Health Services, Substance-Related and Addictive Disorder Services and Severe Mental Illness Benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through U.S Behavioral Health Plan, California (USBHPC) for Inpatient services, Residential Treatment services, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, and Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization, Applied Behavior Analysis (ABA); Methadone Maintenance; and Psychological Testing, except in the event of an Emergency. USBHPC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient and Residential Treatment Medically Necessary Mental Health services provided at an Inpatient Treatment Center	Same as medical plan Inpatient Mental Health Services Copayment[1]
Outpatient Treatment Services provided at the office of a Participating Practitioner or at an Outpatient Treatment Center including Partial Hospitalization /Day Treatment or Intensive Outpatient Treatment	Same as medical plan Outpatient Mental Health Services Copayment
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Substance-Related and Addictive Disorder

Inpatient Treatment Medically Necessary treatment of Substance-Related and Addictive Disorders, including Medical Detoxification, provided at a Participating Facility	Same as medical plan Inpatient Mental Health Services Copayment[1]
Outpatient Treatment including Partial Hospitalization and Intensive Outpatient Treatment	Same as medical plan Outpatient Mental Health Services Copayment
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Severe Mental Illness Benefit[3]

Inpatient and Residential Treatment Unlimited days	Same as medical plan Inpatient Mental Health Services Copayment[1]
Outpatient Treatment including Partial Hospitalization Unlimited visits	Same as medical plan Outpatient Mental Health Services Copayment
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

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

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

[3] Severe Mental Illness diagnoses include: Anorexia Nervosa; Bipolar Disorder; Bulimia Nervosa; Major Depressive Disorders; Obsessive-Compulsive Disorder; Panic Disorder; Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism; Schizoaffective Disorder; Schizophrenia. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED). Please refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for detailed information on this benefit.

WELCOME TO U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA

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

Note: U.S. Behavioral Health Plan, California is the formal legal name of the entity providing your Behavioral Health Care benefits. It operates using the brand name OptumHealth Behavioral Solutions of California. If you see documents labeled or referencing OptumHealth Behavioral Solutions of California, those refer to U.S. Behavioral Health Plan, California.

In July 2010, PacifiCare Behavioral Health of California, Inc. merged into U.S. Behavioral Health Plan, California. Any references you see to PacifiCare Behavioral Health of California now refer to U.S. Behavioral Health Plan, California.

Your UnitedHealthcare of California Medical Plan includes Mental Disorder and **Substance-Related and Addictive Disorder** coverage through U.S. Behavioral Health Plan, California (USBHPC). This coverage includes the treatment of Severe Mental Illness (SMI) for adults and children and treatment for children with Serious Emotional Disturbance (SED). As a USBHPC Member, you and your eligible Dependent always have direct, around-the-clock access to behavioral health benefits. You do not need to go through a Primary Care Physician (PCP) to access you behavioral health benefits, and all services are completely confidential.

This *Combined Evidence of Coverage and Disclosure Form* will help you become more familiar with your Behavioral Health Care benefits. This *Combined Evidence of Coverage and Disclosure Form* should be used in conjunction with your *UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your Behavioral Health Plan and should answers many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 7. Definitions.**

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

What else should I read to understand my benefits?

Along with this Combined Evidence of Coverage and Disclosure Form, be sure to review your USBHPC Schedule of Benefits in this Combined Evidence of Coverage and Disclosure Form and your UnitedHealthcare of California Medical Schedule of Benefits for details of your particular Behavioral Health Plan, including any Copayments or coinsurance that you may have to pay when accessing Behavioral Health Services. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at 1-800-999-9585 or for the hearing and speech impaired use 1-800-842-9489 (TTY).

You may write to USBHPC at the following address:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, CA 94126

Or visit USBHPC's Web site:
www.liveandworkwell.com

SECTION 1. UNDERSTANDING BEHAVIORAL HEALTH: YOUR BENEFITS

- **What are Behavioral Health Services?**
- **What is a Severe Mental Illness?**
- **What is the Serious Emotional Disturbance of a Child?**
- **What does USBHPC do?**

This Section helps you understand what behavioral health services are and provides a general understanding of some of the services U.S. Behavioral Health Plan, California provides.

What are Behavioral Health Services?

Behavioral Health Services are those services provided or arranged by USBHPC for the Medically Necessary treatment of:

- Mental Disorders, including treatment for the Severe Mental Illness of an adult or child and/or the Serious Emotional Disturbance of a Child, and/or
- Alcohol and drug problems, also known as **Substance-Related and Addictive Disorder**, Substance-Related and Addictive or substance abuse.

What is a Mental Disorder?

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Any mental health condition identified as a Mental Disorder in the DSM IV is covered. USBHPC does not cover services for conditions that the DSM IV identifies as something other than a “mental disorder” such as relational problems, e.g. couples counseling or family counseling.

Mental Disorders include a Severe Mental Illness of a Person of Any Age (“Severe Mental Illness” or “SMI”) or A Serious Emotional Disturbance of a Child under the Age of 18 (“Serious Emotional Disturbance of a Child” or “SED”).

What is a Severe Mental Illness?

A Severe Mental Illness (SMI) includes the diagnosis and treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder, including Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

What is the Serious Emotional Disturbance of a Child?

Serious Emotional Disturbance (SED) of a Child is defined as a condition of a child who:

1. Has one or more Mental Disorders as defined by the *Diagnostic and Statistical Manual* current edition, other than a primary Substance-Related and Addictive disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:
   a. 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:
      i. the child is at risk of removal from home or has already been removed from the home; or
      ii. the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
   b. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a Mental Disorder; or
   c. The child meets the special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code of the State of California.

What does U.S. Behavioral Health Plan, California do?

USBHPC arranges for the provision of Behavioral Health Services to our Members.

- You have direct 24-hour phone access to our services.
- Your Medically Necessary Behavioral Health Services are coordinated and paid for as provided under your Behavioral Health Plan, so long as you use USBHPC Participating Providers.
- You may be responsible for payment of some Copayments or Coinsurance amounts, as set forth in the attached *Schedule of Benefits*.

All services covered under this Behavioral Health Plan will be provided by a USBHPC Participating Provider and must be preauthorized by USBHPC, except in the case of an Emergency. All Inpatient services must be preauthorized by USBHPC, except in the event of an Emergency. The following Outpatient treatments must be preauthorized by USBHPC, except in the event of an Emergency: Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 50 minutes, and Psychological Testing. If you have questions about your benefits, simply call the USBHPC Customer Service Department at 1-800-999-9585 at any time. Our staff is always there to assist you 24 hours a day, with understanding your benefits, authorizing services, helping you select a Provider, or anything else related to your USBHPC Behavioral Health Plan.

Your USBHPC Behavioral Health Plan provides coverage for the Medically Necessary treatment of Mental Disorders and **Substance-Related and Addictive Disorder** on both an inpatient and outpatient basis. Details concerning your behavioral health benefits can be found in your *Schedule of Benefits* and in **Section 4** of this *Combined Evidence of Coverage and Disclosure Form*.

SECTION 2. GETTING STARTED: YOUR PARTICIPATING PROVIDER

- **Do I need a referral?**
- **How do I access Behavioral Health Services?**
- **Choice of Physicians and Providers**
- **Continuity of Care**

This Section explains how to obtain USBHPC Behavioral Health Services and the role of USBHPC's Participating Providers.

Do I need a referral from my Primary Care Physician to get Behavioral Health Services?

No. You can call USBHPC directly to obtain Behavioral Health Services. If you would like us to, we will help coordinate the care you receive from your USBHPC Participating Provider and the services provided by your Primary Care Physician (PCP). This may be very important when you have both medical and behavioral health conditions. USBHPC will obtain the appropriate consents before information is released to your PCP. You may call USBHPC Customer Service at any time to start this process.

How do I access Behavioral Health Services?

Step 1

To access Behavioral Health Services, you should call USBHPC first, except in an Emergency. Just call USBHPC Customer Service at 1-800-999-9585. A USBHPC staff member will make sure you are an eligible Member of the USBHPC Behavioral Health Plan and answer any questions you may have about your benefits. The USBHPC staff member will conduct a brief telephone screening by asking you questions, such as:

- What are the problems or symptoms you are having?
- Are you already seeing a Provider?
- What kind of Provider do you prefer?

You will then be given the name and telephone number of one or more USBHPC Participating Providers near your home or work that meets your needs.

Step 2

You call the USBHPC Participating Provider's office to make an appointment. If your request for services is non-urgent, the Participating provider is expected to offer you an appointment within ten (10) working days.

Step 3

You do not need prior approval for routine outpatient services. However, all inpatient services must be pre-authorized. Also certain non-routine outpatient services[1] that you receive from your USBHPC Participating Provider may need pre-authorization from USBHPC, except in the event of an Emergency. After your first visit, your USBHPC Participating Provider will get any necessary approval from USBHPC before you receive these services.

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[1] Non-routine outpatient services are: Intensive Outpatient Program Treatment; Outpatient Electro-Convulsive Treatment; Outpatient Treatment extended beyond 50 minutes; and Psychological Testing. Such services must be provided at the office of the Participating Practitioner or at a participating Outpatient Treatment Center.

Choice of Physicians and Providers

USBHPC's Participating Providers include hospitals, group practices and licensed behavioral health professionals, which include psychiatrists, psychologists, social workers, and marriage and family therapists. All Participating Providers are carefully screened and must meet strict USBHPC licensing and program standards.

Call the USBHPC Customer Service Department for:

- Information on USBHPC Participating Providers,
- Provider office hours,
- Background information such as their areas of specialization,
- A copy of our *Provider Directory*.

Facilities

Along with listing our Participating Providers, your USBHPC Participating Provider Directory has detailed information about our Participating Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Providers. If you need a copy or would like assistance picking you Participating Provider, please call our Customer Service Department. You can also find an online version of the USBHPC Participating Provider Directory at **www.liveandworkwell.com**.

What if I want to change my Participating Provider?

Simply call the USBHPC Customer Service toll-free number at 1-800-999-9585 to select another USBHPC Participating Provider.

If I see a Provider who is not part of USBHPC's Provider Network, will it cost me more?

Yes. If you are enrolled in this USBHPC Behavioral Health Plan and choose to see a Provider who is not part of the USBHPC network, the services will be excluded; and you will have to pay for the entire cost of the treatment (except in an Emergency) with no reimbursement from USBHPC.

Can I call USBHPC in the evening or on weekends?

Yes. If you need services after normal business hours, please call USBHPC's Customer Service Department at 1-800-999-9585. For the hearing and speech impaired, use 1-800-842-9489 (TTY). A staff member is always there to help.

Continuity of Care With a Terminated Provider

In the event your Participating Provider is no longer a part of the USBHPC Provider network for reasons other than breach of contract, a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from that Provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same terminated Provider.

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

1. Continuity of Care services from a terminated Provider must be preauthorized by USBHPC;
2. The requested treatment must be a Covered Service under this Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by USBHPC for current Participating Providers providing similar services who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Services for the Continuity of Care Condition under treatment by the Terminated or Non-Participating Mental Health Provider will be considered complete when:

i. the Member's Continuity of Care Condition under treatment is medically stable, and

ii. there are no clinical contraindications that would prevent a medically safe transfer to a Participating Mental Health Provider as determined by a USBHPC Medical Director (or designee) in consultation with the Member, the Terminated Mental Health Provider and, as applicable, the Member's receiving Participating Provider.

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

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 7. Definitions**, and believe you qualify for continued care with the terminating Provider, please call the Customer Service Department and request the form "Request for Continuity of Care." Complete and return the form to USBHPC as soon as possible, but within thirty (30) calendar days of the Provider effective date of termination.

If you have any questions about this provision or would like a copy of our Continuity of Care Policy, you may call our Customer Service Department.

Continuity of Care for New Members

Under certain circumstances, new Members of USBHPC may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance may be available for a new Member who:

1. Did not have the option to continue with his/her previous behavioral health plan at time of enrollment;
2. Had no other behavioral health plan choice other than through USBHPC;
3. Is under treatment by a Non-Participating Provider at the time of enrollment for an acute or serious chronic mental health condition;
4. Is receiving treatment that is a benefit under this USBHPC Benefit Plan; and
5. Was not offered a plan with an out-of-network option.
6. The Member must be new to USBHPC as a result of the Members' Employer Group changing health plans;

Behavioral Health Services provided by a Non-Participating Provider may be covered by USBHPC for the purpose of safely transitioning you or your Dependent to a USBHPC Participating Provider. If the Behavioral Health Services are preauthorized by USBHPC, USBHPC may cover such services to the extent they would be covered if provided by a USBHPC Participating Provider under the USBHPC Behavioral Health Plan. This means that you will only be responsible for your Copayment or coinsurance listed on the *Schedule of Benefits*. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon USBHPC Participating Providers, including reimbursement methodologies and rates of payment.

These Continuity of Care services, except for Emergency Services, must be approved by USBHPC. If you would like to request continuing treatment from a Non-Participating Provider, call the USBHPC Customer Service Department within 30 days. If you have any questions or would like a copy of USBHPC's continuity-of-care policy, call or write the USBHPC Customer Service Department.

Outpatient Treatment

For outpatient treatment, USBHPC will authorize an appropriate number of Visits for you to continue treatment with the existing Non-Participating Provider in order to transition you safely to a USBHPC Participating Provider.

SECTION 3. EMERGENCY SERVICES AND URGENTLY NEEDED SERVICES

- **What is an Emergency?**
- **What are Psychiatric Emergency Services?**
- **What To Do When You Require Psychiatric Emergency Services**
- **What To Do When You Require Urgently Needed Services**
- **Continuing or Follow-Up of Emergency Treatment**
- **If I am out of State or traveling, am I still covered?**

Worldwide, wherever you are, USBHPC provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

If you believe you are experiencing an Emergency condition, call 911 or go directly to the nearest hospital emergency room or other facility for treatment.

What is an Emergency?

An Emergency is defined as a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected by the Member to result in any of the following:

- Immediate harm to self or others;
- Placing your health in serious jeopardy;
- Serious impairment of your functioning; or
- Serious dysfunction of any bodily organ or part.

A situation will be considered an Emergency if you or your Dependent are experiencing a situation which requires the immediate provision of Behavioral Health Services such that a delay caused by seeking treatment from a USBHPC Participating Provider would result in a serious deterioration to your mental health.

What are Psychiatric Emergency Services?

Psychiatric Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 Emergency response system. It includes the medical screening, examination and evaluation by a Physician, or other licensed personnel – to the extent provided by law – to determine if a Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment by a Physician necessary to stabilize or eliminate the Emergency condition within the capabilities of the facility.

What To Do When You Require Psychiatric Emergency Services

Step 1: In an Emergency, get help or treatment immediately.

This means you should call 911 or go directly to the nearest medical facility for treatment.

Step 2: Then, within 48 hours of your Emergency, or as soon as is reasonably possible after your condition is stable, you, or someone acting on your behalf, must call USBHPC at 1-800-999-9585.

This is important.

Psychiatric Emergency Services are covered only as long as the condition continues to be an Emergency. Once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the Emergency care facility will not be covered.

Step 3: USBHPC will arrange follow up services for your condition after an Emergency. USBHPC may move you to a Participating Provider in our network, as long as the move would not harm your health.

It is appropriate for you to use the 911 Emergency response system, or alternative Emergency system in your area, for assistance in an Emergency situation when ambulance transport services are required and you reasonably believe that your condition is immediate, serious and requires Emergency transport services to take you to the appropriate facility.

What To Do When You Require Urgently Needed Services

In-Area Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Provider, you should contact your Participating Provider. If you are calling during nonbusiness hours, and your Participating Provider is not immediately available, call USBHPC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or USBHPC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

Out-of-Area Urgently Needed Services

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

When you are temporarily outside the geographic area served by your Participating Provider, and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Participating Provider. If you are calling during nonbusiness hours, and your Provider is not immediately available, call USBHPC Customer Service Department for assistance in finding a Provider near your area. If your Participating Provider or USBHPC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

You, or someone else on your behalf, must notify USBHPC or your Participating Provider within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services.

It is very important that you follow the steps outlined above. If you do not, you may be financially responsible for services received.

Continuing or Follow-up of Emergency Treatment or Urgently Needed Services

If you require Behavioral Health Services following an Emergency or Urgently Needed Services and you desire that these services be covered, the Behavioral Health Services must be coordinated and authorized by USBHPC. In addition, if a transfer does not create an unreasonable risk to your health, USBHPC may require that you transfer to a USBHPC Participating Provider designated by USBHPC for any treatment following the Emergency or Urgently Needed Services.

Failure to transfer or to obtain approval from USBHPC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the Emergency or Urgently Needed Services criteria outlined in this document.

If I am out of State or traveling, am I still covered?

Yes, but only in an Emergency or Urgent situation. If you think you are experiencing an Emergency or require Urgently Needed Services, get treatment immediately. Then, as soon as reasonably possible, call USBHPC

Customer Service Department to ensure your Emergency Treatment or Urgently Needed Services are covered. **This is important**.

If you are traveling outside of the United States, you can reach USBHPC by calling 1-877-447-5915 for additional instructions on what to do in the case of an Emergency or Urgent situation.

Note: Under certain circumstances, you may need to pay for your Emergency or Urgently Needed Services at the time of treatment. If this is necessary, please pay for such services and then contact USBHPC at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to USBHPC, please refer to **Section 5. Overseeing Your Behavioral Health Services** in this *Combined Evidence of Coverage and Disclosure Form.*

SECTION 4. COVERED BEHAVIORAL HEALTH SERVICES

- **What Behavioral Health Services are covered?**
- **Exclusions and Limitations**

This section explains your Behavioral Health Benefits, including what is and is not covered by USBHPC. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you need to refer to your Schedule of Benefits, a copy of which is included with this document.

What Behavioral Health Services are covered?

Behavioral Health Services are covered only when they are:

- Incurred while the Member is eligible for coverage under this Behavioral Health Plan;
- Medically Necessary;
- Preauthorized by USBHPC as required for Inpatient services and certain Outpatient Services -- Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 50 minutes and Psychological Testing – except in the event of an Emergency; and
- Rendered by a USBHPC, except in the case of an Emergency.

USBHPC will pay for the following Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or **Substance-Related and Addictive Disorder** as outlined in the *Schedule of Benefits*, provided the above criteria have been satisfied. You should refer to your *Schedule of Benefits* for further information about your particular Behavioral Health Plan.

I. Mental Health Services (including services for the diagnosis and treatment of SMI and SED conditions:

A. **Inpatient**

1. **Inpatient Mental Health Services** provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, preauthorized by USBHPC, and provided at a Participating Facility.
2. **Inpatient Physician Care** – Medically Necessary Mental Health Services provided by a Participating Practitioner while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Day Treatment Center and which have been preauthorized by USBHPC.

B. **Outpatient**

1. **Outpatient Physician Care** – Medically Necessary Mental Health Services provided by a Participating Practitioner and preauthorized by USBHPC, when appropriate, i.e. Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 50 minutes, and Psychological Testing. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

II. Substance-Related and Addictive Disorder Services

A. **Inpatient**

1. **Inpatient Substance-Related and Addictive Disorder Services, including Medical Detoxification provided at an Inpatient Treatment Center** – Medically Necessary **Substance-Related and Addictive Disorder** Services, including Medical Detoxification, which have been preauthorized by USBHPC and are provided by a Participating Practitioner while the Member is confined in a Participating Inpatient Treatment Center, or at a Participating Residential Treatment Center.

2. **Inpatient Physician Care** – Medically Necessary **Substance-Related and Addictive Disorder** Services, including Medical Detoxification, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been preauthorized by USBHPC.
3. **Medical Detoxification** – Medical Detoxification services are covered when provided by a Participating Practitioner at a Participating Inpatient Treatment Center or at a Residential Treatment Center when preauthorized by USBHPC.
4. **Substance-Related and Addictive Disorder Services Rendered at a Residential Treatment Center** – Medically Necessary **Substance-Related and Addictive Disorder** Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and preauthorized by USBHPC.

B. **Outpatient**

1. **Medical Detoxification** – Medical Detoxification services are covered when provided by a Participating Practitioner at a Participating Outpatient Treatment Center or by a Participating Practitioner.
2. **Outpatient Physician Care** – Medically Necessary **Substance-Related and Addictive Disorder** Services provided by a Participating Practitioner. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

III. Other Behavioral Health Services

1. **Ambulance** – Use of an ambulance (land or air) for Emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 Emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services. Use of an ambulance for a non-Emergency is covered only when specifically authorized by USBHPC.
2. **Laboratory Services** – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Disorder and/or **Substance-Related and Addictive Disorder**.
3. **Inpatient Prescription Drugs** – Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder or **Substance-Related and Addictive Disorder** while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of **Substance-Related and Addictive Disorder** a Residential Treatment Center.
4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder.
5. **Psychological Testing** – Medically Necessary psychological testing is covered when preauthorized by USBHPC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

Exclusions and Limitations

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage under this Behavioral Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*.

1. Any Inpatient confinement, treatment, service or supply not authorized by USBHPC, except in the event of an Emergency.

2. The following Outpatient treatments require preauthorization by USBHPC, except in the event of an Emergency: Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 50 minutes, and Psychological Testing.
3. All services not specifically included in the USBHPC *Schedule of Benefits* included with this *Combined Evidence of Coverage and Disclosure Form*.
4. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
5. Services or treatments which are not Medically Necessary, as determined by USBHPC.
6. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable workers' compensation laws are not covered.
7. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Behavioral Health Plan is expressly required by federal or state law.
8. Speech therapy, physical therapy and occupational therapy services provided for Developmental Delays or Learning Disabilities are not covered. Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive and/or social development. A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. This exclusion does not apply to Medically Necessary speech therapy, physical therapy and occupational therapy services for Pervasive Developmental Disorders or Autism when authorized and are provided by a participating provider acting within the scope of his or her license under California law.
9. Treatments which do not meet national standards for mental health professional practice.
10. Routine custodial and convalescent care.
11. Any services provided by nonlicensed Providers.
12. Pastoral or spiritual counseling.
13. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.
14. School counseling and support services, household management training, peer-support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability and interpretation services.
15. Genetic counseling services.
16. Community care facilities that provide 24-hour nonmedical residential care.
17. Weight control programs and treatment for addictions to tobacco, nicotine or food.
18. Counseling for adoption, custody, family planning or pregnancy in the absence of the *Diagnostic and Statistical Manual* current edition diagnosis.
19. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence.
20. Personal or comfort items, and non-Medically Necessary private room and/or private-duty nursing during inpatient hospitalization are not covered.
21. With the exception of injectable psychotropic medication as set forth in **Section 4**, all nonprescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Nonprescription and prescription drugs prescribed by a

USBHPC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and nonprescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner are covered under the inpatient benefit.)

22. Surgery..
23. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
24. Neurological services and tests, including, but not limited to, EEGs, PET scans, beam scans, MRIs, skull X-rays and lumbar punctures.
25. Treatment sessions by telephone or computer Internet services.
26. Evaluation for professional training, employment investigations, fitness for duty evaluations or career counseling.
27. **Educational Services for Developmental Delays and Learning Disabilities** – Educational Services for Developmental Delays and Learning Disabilities are not health care services and are not covered. Educational skills related to or consisting of gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress: academic coaching, teaching members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills that help you progress from your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

    We refer to *American Academy of Pediatrics*, *Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services.

    For example, we do not cover:

    - Items and services that increase academic knowledge or skills
    - Special education (teaching to meet the educational needs of a person with mental retardation, Learning Disability, or Developmental Delay. (A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to covered services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed healthcare professional, and are provided by a Participating Provider acting within the scope of his or her license under California law for the treatment of Pervasive Developmental Disorder or Autism.
    - Teaching and support services to increase academic performance
    - Academic coaching or tutoring for skills such as grammar, math, and time management
    - Speech training that is intended to address speech impediments, such as lisping and stuttering, that are not caused by an illness or injury. This exclusion does not apply to Speech Therapy when part of a Medically Necessary treatment plan for Pervasive Developmental Disorders or Autism, provided by or rendered under the direct supervision of a licensed therapist, and are provided by a Participating Provider acting within the scope of his or her license under California law.
    - Teaching you how to read, whether or not you have dyslexia
    - Educational testing

- Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play.

28. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.
29. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the USBHPC Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form,* procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met:

    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
    - It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
    - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
    - The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
    - It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy.)
    - The source of information to be relied upon by USBHPC in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include, but are not limited to the following:
        - The Member's Medical records;
        - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
        - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
        - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
        - Expert medical opinion;
        - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);

- Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
- USBHPC Technology Assessment Committee Guidelines.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external independent review of USBHPC's coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies."

30. All exclusions and limitations listed in the UnitedHealthcare of California Group *Subscriber Agreement* and EOC under the "Exclusions and Limitations" section.
31. Methadone maintenance treatment is not covered.
32. Services provided to the Member on an Out-of-Network basis.
33. Services rendered by a Non-Participating Provider are not covered, except for Emergency Services or services authorized by USBHPC.
34. Services rendered outside the Service Area are not covered, except for Emergency Services or Urgently Needed Services.
35. Services following discharge after receipt of Emergency Services or Urgently Needed Services are not covered without a Participating Provider's or USBHPC's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from a Participating Provider will not entitle the Member to coverage.

SECTION 5. OVERSEEING YOUR BEHAVIORAL HEALTH SERVICES

- **How USBHPC Makes Important Benefit Decisions**
- **Second Opinions**
- **New Treatment and Technologies**
- **Experimental and Investigational Therapies**
- **Appealing a Behavioral Health Benefit Decision**
- **Independent Medical Review**

This section explains how USBHPC authorizes or makes changes to your Behavioral Health Services, how we evaluate new behavioral health technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your Behavioral Health Plan, including how to appeal a behavioral health benefit decision by USBHPC or one of our Participating Providers. You will learn the process that is available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How USBHPC Makes Important Benefit Decisions

Authorization, Modification and Denial of Behavioral Health Services

When a Member requests Mental Health Services or **Substance-Related and Addictive Disorder** Services, USBHPC uses established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating Mental Health Services are based on empirical research and industry standards. These are the *MCAP Behavioral Health Criteria*. For **Substance-Related and Addictive Disorder** Services USBHPC uses the *American Society of Addiction Medicine Placement Guidelines for Substance Related Disorder – Version II-Revised*. The UM criteria used to deny, delay or modify requested services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guideline, based on a particular diagnosis, upon request.

If you or your Dependent(s) are receiving Behavioral Health Services from a school district or a regional center, USBHPC will coordinate with the school district or regional center to provide Case Management of your Behavioral Health Treatment Program. Upon USBHPC's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

The USBHPC qualified Physician or other appropriate qualified licensed health care professional, and its Participating Providers make decisions to deny, delay or modify requests for authorization of Behavioral Health Services, based on Medical Necessity, within the following time frames as required by California state law:

- Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from USBHPC's receipt of information reasonably necessary to make the decision.
- If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the decision would be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed twenty-four (24) hours after USBHPC's receipt of the information reasonably necessary and requested by USBHPC to make the determination.

If the decision cannot be made within these time frames because (i) USBHPC is not in receipt of all the information reasonably necessary and requested, or (ii) USBHPC requires consultation by an expert reviewer, or

(iii) USBHPC has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, USBHPC will notify the Participating Provider and the Member, in writing, that a decision cannot be made within the required time frame. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by USBHPC, then USBHPC shall approve or deny the request for authorization within the time frame specified above as applicable.

USBHPC notifies requesting Participating Providers of decisions to deny or modify request for authorization of Behavioral Health Services of Members within twenty-four (24) hours of the decision. Members are notified of decisions, in writing, within two (2) 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, and information about how to file an appeal of the decision with USBHPC. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request" as defined above, USBHPC will modify or deny the request as soon as possible, taking into account the Member's behavioral health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to USBHPC at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, USBHPC will treat the request as a new request for a Covered Service under the Behavioral Health Plan and will follow the time frame for non-Urgent requests as discussed above.

If you would like a copy of USBHPC's description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact the USBHPC Customer Service Department or visit the USBHPC Web site at www.liveandworkwell.com.

Second Opinions

A Member, or his or her treating USBHPC Participating Provider, may submit a request for a second opinion to USBHPC either in writing or verbally through the USBHPC Customer Service Department. Second opinions will be authorized for situations, including, but not limited to, when:

- the Member questions the reasonableness or necessity of recommended procedures;
- the Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition;
- the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Provider is unable to diagnose the condition and the Member requests an additional diagnosis;
- the Treatment Plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- the Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

The request for a second opinion will be approved or denied by USBHPC's Medical Director (or designee) in a timely fashion appropriate for the nature of your or Dependent's condition. For circumstances other than an imminent or serious threat to your health, a second opinion request will be approved or denied within five business days after the Participating Provider or USBHPC receives the request. When there is an imminent and

serious threat to your behavioral health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Provider or USBHPC.

If you are requesting a second opinion about care given by your Participating Provider, the second opinion will be provided by an appropriately qualified behavioral health professional of your choice within the same Participating Provider Network. If you request a second opinion about care received from a specialist the second opinion will be provided by any behavioral health care professional of your choice from within the same Participating Provider Network. The Participating Provider providing the second opinion will possess the clinical background, including training and expertise, related to the illness or condition associated with the request for a second opinion.

If there is no qualified Participating Provider within the network, then USBHPC will authorize a second opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, USBHPC will take into account the ability of the Member to travel to the Provider.

A second opinion will be documented by a consultation report which will be made available to you. If the Provider giving the second opinion recommends a particular treatment, diagnostic test or service covered by USBHPC, and it is determined to be Medically Necessary by your Participating Provider, the treatment, diagnostic test or service will be provided or arranged by the Member's Participating Provider. However, the fact that a Provider furnishing a second opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically Necessary or a Covered Service under your USBHPC Behavioral Health Plan. You will be responsible for paying any Copayment, as set forth in your *Schedule of Benefits*, to the USBHPC Provider who renders the second opinion. If you obtain a second opinion without preauthorization from your Participating Provider or USBHPC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, USBHPC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the appeals section described below.

To receive a copy of the Second Opinion policy, you may call or write the USBHPC Customer Service Department at:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, CA 94126
1-800-999-9585

How are new treatment and technologies evaluated?

USBHPC is committed to evaluating new treatments and technologies in behavioral health care. A committee composed of USBHPC's Medical Director and people with subject matter expertise meet at least once a year to assess new advances and programs.

Experimental and Investigational Therapies

USBHPC also provides an external independent review process to review its coverage decisions regarding experimental or investigational therapies for USBHPC Members who meet all of the following criteria:

1. You have a Life-Threatening or Seriously Debilitating condition, as defined below and it meets the criteria listed in items #2, #3, #4 and #5 below:
   - "Life-threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.
   - "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.

2. Your USBHPC Participating Provider certifies that you have a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by USBHPC than the therapy proposed pursuant to paragraph (3); and
3. Either (a) your USBHPC Participating Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation; or (b) you, or your non-Contracting Physician who is a licensed, board-certified or board-eligible Physician or Provider qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from medical and scientific evidence (as defined in California Health and Safety Code Section 1370.4(d)), is likely to be more beneficial for you than any available standard therapy.

   Such certification must include a statement of the evidence relied upon by the Physician in certifying his or her recommendation. USBHPC is not responsible for the payment of services rendered by non-Contracting Providers that are not otherwise covered under the Member's USBHPC benefits; and
4. A USBHPC Medical Director (or designee) has denied your request for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3); and
5. The treatment, drug, device, procedure or other therapy recommended pursuant to paragraph 3, above, would be a Covered Service, except for USBHPC's determination that the treatment, drug, device, procedure or other therapy is experimental or investigational. Independent Medical Review for coverage decisions regarding Experimental or Investigational therapies will be processed in accordance with the protocols outlined under "Independent Medical Review Involving a Disputed Health Care Service" Section of this *Evidence of Coverage.*

Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" Section found later in this *Combined Evidence of Coverage and Disclosure Form* for more information.

What to do if you have a problem?

Our first priority is to meet your needs and that means providing responsive service. If you ever have a question or problem, your first step is to call the USBHPC Customer Service Department for resolution.

If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint within 180 days of your receipt of an initial determination over the telephone by calling the USBHPC toll-free number at 1-800-999-9585. You can also file a complaint in writing:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, CA 94126
Attn: Appeals Department

Or at the USBHPC Web site: **www.liveandworkwell.com**

Behavioral Health Grievance Procedures
If your grievance involves Mental Health or Substance Abuse Services call U.S. Behavioral Health Plan, California (USBHPC) at 1-800-999-9585, or write to:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, CA 94126
Attn.: Appeals Department

The member may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

USBHPC will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information. To make a request, contact Customer Service at 1-800-999-9585.

If USBHPC upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to the Member:

- For FABDs involving medical judgment, the member may pursue the Independent External Review process described below;
- For FABDs involving benefit, the Member may pursue the CalPERS Administrative Review process as described in the CalPERS Administrative Review section. *[or you may initiate voluntary mediation, or binding arbitration, as described in the Voluntary Mediation and Binding Arbitration section.]*

Urgent Decision

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if USBHPC determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If USBHPC determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

> ***Note:*** If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR, at 1-888-HMO-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

Experimental or Investigational Denials

USBHPC does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if USBHPC denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of USBHPC's decision from the DMHC. ***Note:*** DMHC does not require you to exhaust USBHPC's appeal process before requesting an IMR of ABD's based on Experimental or Investigational Services. In such cases, you may immediately contact DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process, you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form by calling us at 1-800-

999-9585 or write to us at U.S. Behavioral Health Plan, California, P.O. Box 2839, San Francisco, CA 94126. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- Your *medical group/physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this *plan* that is more beneficial than the proposed treatment.
- The proposed treatment must either be:
  - Recommended by a/an USBHPC provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - Requested by you or by a licensed board certified or board eligible doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
    - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
    - Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
    - Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
    - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
    - Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *doctor*. Any newly developed or discovered relevant medical records that we or a USBHPC *provider* identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your *doctor* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Independent Medical Review (IMR) Involving a Disputed Health Care Service

You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your USBHPC Plan have been improperly denied, modified or delayed, in whole or in part, by USBHPC or one of its providers because the service is deemed not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review.
You have the right to provide information in support of the request for an IMR. USBHPC must provide you with an IMR application form and USBHPC's FABD letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against USBHPC regarding the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:

   (a) Your provider has recommended a health care service as *medically necessary*, or

   (b) You have had *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

   (c) You have been seen by a USBHPC *provider* for the diagnosis or treatment of the medical condition for which you want an IMR;

2. The disputed health care service has been denied, changed, or delayed by us or your *medical group*, based in whole or in part on a decision that the health care service is deemed not *medically necessary*; **and**

3. You have filed a complaint with us or your *medical group* and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of USBHPC. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor USBHPC will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance Procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds USBHPC's FABD, you may have additional review rights under the CalPERS Administrative Review section.

For more information regarding the IMR process or to request an application form, please call Customer Service at 1-800-999-9585.

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 toll free at 1-877-359-3714 (TTY users call1-855-479-3660) 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 an appeal involving an emergency, an appeal that has not been satisfactorily resolved by your health plan, or an appeal that has remained unresolved for more than 30 days, you may call DMHC for assistance.

You may also be eligible for an IMR. If you are eligible for an 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. DMHC also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. DMHC's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and online instructions.

In the event that USBHPC should cancel or refuse to renew enrollment for you or your dependents and you feel that such action was due to health or utilization of benefits, you or your dependents may request a review by the DMHC Director.

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections, Grievance Procedures, Experimental or Investigational Denials, Independent Medical Review (IMR) Involving a Disputed Health Care Service, and Department of Managed Health Care, you have additional dispute resolution options, as follows below:

1. Eligibility issues

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Member Account Management Division
Attn: Enrollment Administration
P.O. Box 942714
Sacramento, CA 94229-2714

888 CalPERS (or **888**-225-7377) CalPERS Customer Service and Outreach Division toll free telephone number1-916-795-1277 fax number

2. Coverage Issues

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this EOC booklet. It does not include a plan or contracting provider decision regarding a Disputed Health Care Service.

If you are dissatisfied with the outcome of USBHPC's internal appeal process or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court, *[or initiate voluntary mediation or binding arbitration]*. Upon exhaustion of the DMHC review process, you may then request a CalPERS Administrative Review. You may **not** request a CalPERS Administrative Review if you decide to proceed to court, *[or initiated voluntary mediation or binding arbitration].*

3. Malpractice and Bad Faith

You must proceed directly to court.

4. Disputed Health Care Service Issue

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not medically necessary, or Experimental or Investigational.

If you are dissatisfied with the outcome of USBHPC's internal grievance process or if you have been in the process for 30 days or more, you may request an IMR from the DMHC.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to court. If you choose to proceed to court, you may **not** request a CalPERS Administrative Review.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with USBHPC's Appeal Process determination, you can request that USBHPC 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 USBHPC. 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.

CalPERS Administrative Review

If you remain dissatisfied with USBHPC's determination, the DMHC's determination or the IMR's determination, the Member may request an Administrative Review. The Member must exhaust USBHPC's internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC FABD or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

The Member is encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. If the Member would like to designate an Authorized Representative to represent him/her in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. The Member must complete and sign the form. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding a Member's request for Administrative Review. The ARHI form will be provided to the Member with the FABD letter from USBHPC. If the Member has additional medical records from Providers or scientific studies that the Member believes are relevant to CalPERS review, those records should be included with the written request. The Member should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. The Member is responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) calendar days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if the Member requests an IMR at the same time the Member submits a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue its determination until the IMR determination is issued.

Administrative Hearing

The Member must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

The Member must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); the Member may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to the Member within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

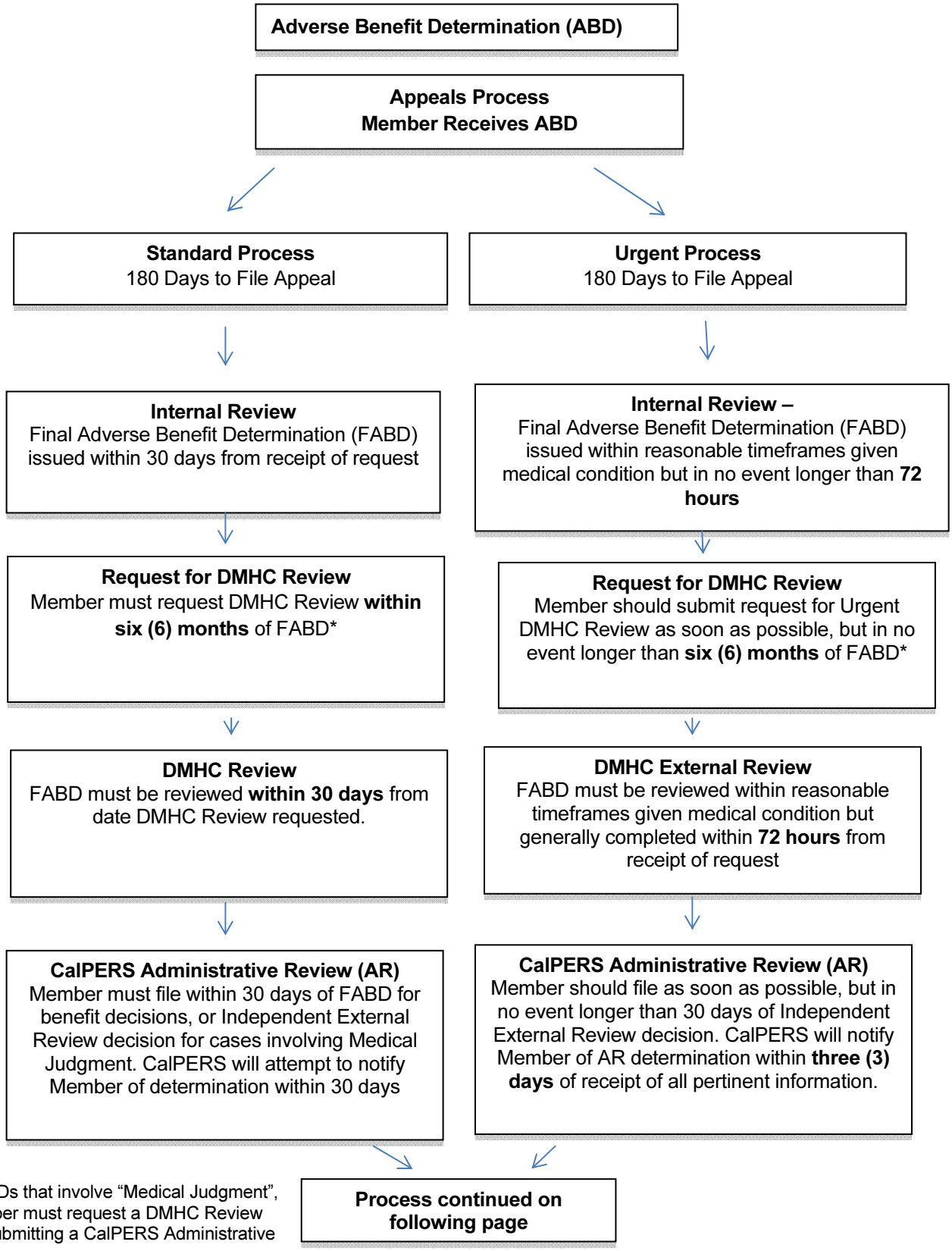
If the Member is still dissatisfied with the Board's decision, the Member may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

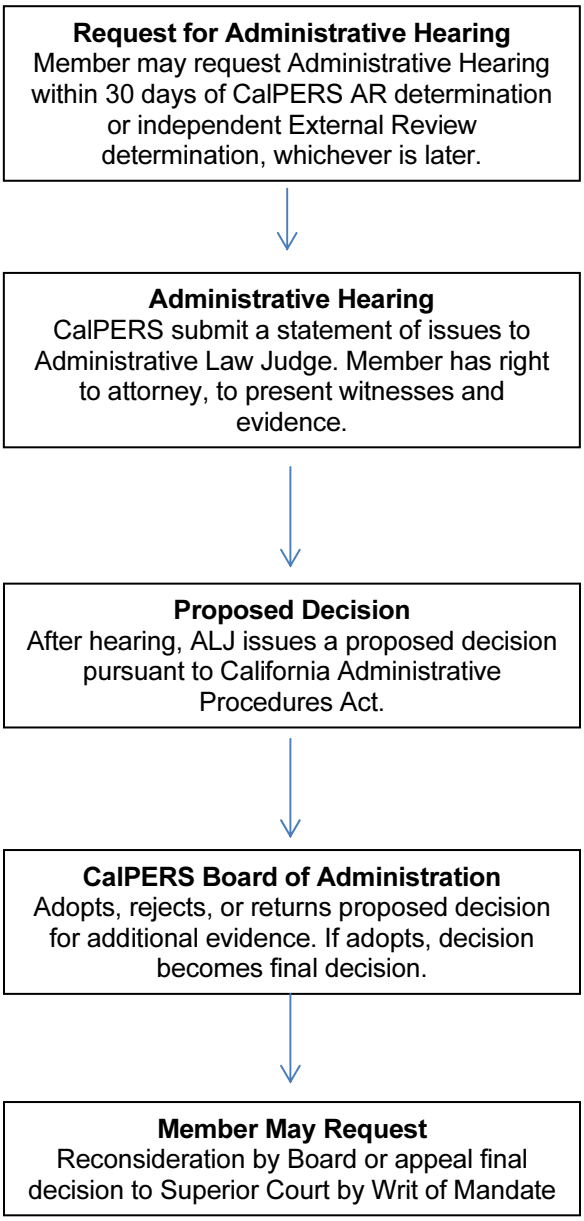
- Right to records, generally. The Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- Records subject to attorney-client privilege. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- Attorney Representation. At any stage of the appeal proceedings, the Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.
- Right to experts and consultants. At any stage of the proceedings, the Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

APPEAL CHART



*For FABDs that involve "Medical Judgment", the Member must request a DMHC Review prior to submitting a CalPERS Administrative review

Administrative Hearing Process



SECTION 6. GENERAL INFORMATION

- **What if I get a Bill?**
- **Your Financial Responsibilities**
- **Termination of Benefits**
- **Confidentiality of Information**
- **Translation Assistance**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Suspected Health Care Fraud**
- **Public Policy Participation**

What follows are answers to some questions about your coverage. If you have any questions of your own that have not been answered, please call our Customer Service Department.

What if I get a bill?

You should not get a bill from you USBHPC Participating Provider because USBHPC's Participating Providers have been instructed to send all their bills to us for payment. You may, however, have to pay a Copayment to the Participating Provider each time you receive services. You could get a bill from an emergency room Provider if you use Emergency care. If this happens, send USBHPC the original bill or claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your Copayment, as described in the *Schedule of Benefits* in this *Evidence of Coverage and Disclosure Form*.

Forward the bill to:

U.S. Behavioral Health Plan, California
Claims Department
P.O. Box 30602
Salt Lake City, UT 84130-0602

Your Financial Responsibility

Please refer to the "Payment Responsibility" section of your UnitedHealthcare of California Medical *Combined Evidence of Coverage and Disclosure Form.*

Termination of Benefits

Please refer to the "Termination of Benefits" section of your UnitedHealthcare of California Medical *Combined Evidence of Coverage and Disclosure Form*.

Confidentiality of Information

USBHPC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all Member information in its possession, including the protection of treatment records and personal information. USBHPC provides information only to the professionals delivering your treatment or as otherwise required by law.

Confidentiality is built into the operations of USBHPC through a system of control and security that protects both written and computer-based information.

A statement describing USBHPC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. If you would like a copy of USBHPC's confidentiality policies and procedures, you may call our Customer Service Department at 1-800-999-9585.

Does USBHPC offer a translation service?

USBHPC uses a telephone translation service for almost 140 languages and dialects. That is in addition to the selection of Customer Service representatives who are fluent in a language other than English.

Does USBHPC offer hearing and speech-impaired telephone lines?

USBHPC has a dedicated telephone number for the hearing and speech impaired. This phone number is 1-800-842-9489 (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 Participating Providers will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. USBHPC will later provide appropriate reimbursement.

How does USBHPC compensate its Participating Providers?

USBHPC itself is not a Provider of Behavioral Health Services. USBHPC typically contracts with independent Providers to provide Behavioral Health Services to its Members and with hospitals to provide hospital services. Once they are contracted, they become USBHPC Participating Providers. USBHPC's network of Participating Providers includes individuals practitioners, group practices and facilities.

USBHPC Participating Providers who are groups, or facilities may in turn employ or contract with individual psychiatrists, psychologists or other licensed behavioral health professionals. None of the Participating Providers or their employees are employees or agents of USBHPC. Likewise, neither USBHPC nor any employee of USBHPC is an employee or agent of any Participating Provider.

Our USBHPC Participating Providers are paid on a discounted fee-for-service basis for the services they provide. They have agreed to provide services to you at the normal fee they charge, minus a discount. USBHPC does not compensate nor does it provide any financial bonuses or any other incentives to its Providers based on their utilization patterns.

If you would like to know more about fee-for-service reimbursement, you may request additional information from the USBHPC Customer Service Department or your USBHPC Participating Provider.

What do you do if you suspect health care fraud?

USBHPC takes health care fraud by its Participating Providers or by its employees very seriously and has taken great measures to prevent, detect and investigate health care fraud. USBHPC has put in place policies and procedures to address fraud and report fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of health care fraud. If you suspect fraud by any USBHPC Participating Provider or any USBHPC employee, please call the USBHPC anti-fraud hotline at800-455-4521.

How can I participate in USBHPC'S Public Policy Participation?

USBHPC affords its Members the opportunity to participate in establishing its public policy. For the purpose of this paragraph, "public policy" means acts performed by USBHPC and its employees to assure the comfort, dignity and convenience of Members who rely on Participating Providers to provide Covered Services. USBHPC members comprise at least 51% of USBHPC's Public Policy Committee. If you are interested in participating in the establishment of USBHPC's public policy, please call the USBHPC Customer Service Department for more details.

SECTION 7. DEFINITIONS

U.S. Behavioral Health Plan, California is dedicated to making its services easily accessible and understandable. To help you understand the precise meaning of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Combined Evidence of Coverage and Disclosure Form, as well as the Schedule of Benefits. Please refer to the Schedules of Benefits to determine which of the definitions below apply to your benefit plan.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders and **Substance-Related and Addictive Disorder**, which are provided to Members pursuant to the terms and conditions of the USBHPC Behavioral Health Plan.

Behavioral Health Plan. The USBHPC Behavioral Health Plan that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and **Substance-Related and Addictive Disorder**, as described in the Behavioral Health Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits*.

Behavioral Health Treatment ("BHT"). Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a licensed Participating Physician of the California Business and Professions Code or developed by a licensed Participating psychologist.
- The treatment is provided under a treatment plan prescribed by a Participating Qualified Autism Service Provider and is administered by one of the following:
- A Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Professional supervised and employed by the Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Paraprofessional supervised and employed by a Participating Qualified Autism Service Provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the Participating Qualified Autism Service Provider does all of the following:
- Describes the Member's behavioral health impairments to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

Behavioral Health Treatment Plan. A written clinical presentation of the USBHPC Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to a USBHPC for review as part of the concurrent review monitoring process.

Behavioral Health Treatment Program. A structured treatment program aimed at the treatment and alleviation of **Substance-Related and Addictive Disorder** and/or Mental Disorders.

Benefit Plan Design. The specific behavioral health Benefit Plan Design for a Behavioral Health Plan which describes the benefit coverage, pertinent terms and conditions for rendering Behavioral Health Services, and the exclusions or limitations applicable to the Covered Behavioral Health Services.

Calendar Year. The period of time commencing 12 a.m. on January 1 through 11:59 p.m. on December 31.

Case Management. A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral health needs based on Medical Necessity, behavioral health covered services in order to promote a quality outcome for the individual Member.

Continuity of Care Condition(s). The completion of Covered Services will be provided by a terminated Participating Provider to a Member who at all time of the Participating Provider's contract termination was receiving any of the following Covered Services from that Participating Provider:

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.
2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time reasonably necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Provider, as determined by the USBHPC Medical Director (or designee) in consultation with the Member, the terminated Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination.
3. Other Procedure: Other procedure that has been authorized by USBHPC or the Member's assigned Participating Provider as part of a documented course of treatment and had been recommended and documented by the terminated Participating Provider to occur within 180 calendar days of the Agreement's termination date.

Copayments. Costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of covered charges as specified in this *Combined Evidence of Coverage and Disclosure Form* and are shown on the USBHPC *Schedule of Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* for Emergencies or those Behavioral Health Services.

Custodial Care. Personal services required to assist the Member in meeting the requirements of daily living. Custodial Care is not covered under this USBHPC Behavioral Health Plan. Such services include, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding or using the lavatory, preparation of special diets and supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Customer Service Department. The department designated by USBHPC to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-800-999-9585 or in writing at:

U.S. Behavioral Health Plan, California
Post Office Box 2839
San Francisco, CA 94126

Day Treatment Center. A Participating Facility which provides a specific Behavioral Health Treatment Program on a full- or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Participating Practitioner and which is also licensed, certified or approved to provide such services by the appropriate state agency.

Dependent. Any Member of a Subscriber's family who meets all the eligibility requirements set forth by the Employer Group under this USBHPC Behavioral Health Plan and for whom applicable Plan Premiums are received by USBHPC.

Developmental Delay. A delayed attainment of the age appropriate milestones in the areas of speech-language, motor, cognitive and social development.

Diagnostic and Statistical Manual (or "DSM"). The current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of **Substance-Related and Addictive Disorder** and Mental Disorders.

Domestic Partner is a person who meets the eligibility requirements, as defined by your Employer Group, and the following:

i. Is eighteen (18) years of age or older;

ii. Is mentally competent to consent to contract;

iii. Resides with the Subscriber and intends to do so indefinitely;

- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and

vi. Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Emergency or Emergency Services. A behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the Prudent Layperson would expect the absence of immediate Behavioral Health Services to result in any of the following:

- Immediate harm to self or others;
- Placing one's health in serious jeopardy;
- Serious impairment of one's functioning; or
- Serious dysfunction of any bodily organ or part.

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the 911 Emergency response system and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if an Emergency for a Behavioral Health condition exists, and if it does, the care and treatment by a Practitioner necessary to relieve or eliminate the Emergency within the capabilities of the facility.

Experimental and Investigational. Please refer to the "Experimental and Investigational Therapies" section of this *Combined Evidence of Coverage and Disclosure Form*.

Employer Group. An employer, labor union, trust, organization, association or other entity to which the USBHPC Group Subscriber Agreement has been issued.

Family Member. The Subscriber's Spouse or Domestic Partner and any person related to the Subscriber, Spouse or Domestic Partner by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with USBHPC, meets all the eligibility requirements of the Subscriber's Employer Group and USBHPC, and for whom Premiums have been received by USBHPC. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and USBHPC.

Group Subscriber Agreement. The Agreement for the provision of Behavioral Health Services between the Group and USBHPC.

Group Therapy. Goal-oriented Behavioral Health Services provided in a group setting (usually about six to 12 participants) by a USBHPC Participating Practitioner. Group Therapy can be made available to the Member in lieu of individual outpatient therapy.

Inpatient Treatment Center. An acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC Participating Practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.

Learning Disability. A condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

Limiting Age. The age established by the Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage.

Medical Detoxification. The medical treatment of withdrawal from alcohol, drug or other substance addiction is covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of USBHPC to be all of the following:

a. A health intervention for the purpose of treating a Mental Disorder or **Substance-Related and Addictive Disorder**;

b. The most appropriate level of service or item, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

A service or item will be covered under the USBHPC Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meaning:

i. *Treating Practitioner* means a Practitioner who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnosis, detect, treat or palliate) a Mental Disorder or **Substance-Related and Addictive Disorder** or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder and **Substance-Related and Addictive Disorder** condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the Mental Disorder or **Substance-Related and Addictive Disorder** condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A *new intervention* is one that is not yet in widespread use for the Mental Disorder or **Substance-Related and Addictive Disorder** and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

Member. The Subscriber or any Dependent who is enrolled, covered and eligible for USBHPC Behavioral Health Care coverage.

Mental Disorder. A mental or nervous condition diagnosed by a licensed practitioner according to the criteria in the *Diagnostic and Statistical Manual* current edition resulting in the impairment of a Member's mental, emotional or behavioral functioning. Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a Child.

Mental Health Services. Medically Necessary Behavioral Health Services for the treatment of Mental Disorders.

Non-Participating Providers. Licensed psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and other behavioral health professionals, hospitals and other licensed behavioral health facilities which provide Behavioral Health Services to eligible Members, but have not entered into a written agreement with USBHPC to provide such services to Members.

Outpatient Treatment Center. A licensed or certified Participating Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

Partial Hospitalization/Day Treatment Program. A structured ambulatory program that may be freestanding or hospital-based and that provides services for at least five (5) hours per day and at least four (4) days per week. Partial hospital programs are used as a step-up from routine or intensive outpatient services, or as a step-down from acute inpatient or residential care. Partial hospital programs can be used to treat mental health conditions or substance-related and addictive disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-related and addictive disorders.

Participating Facility. An Inpatient Treatment Center, Day Treatment Center, Outpatient Treatment Center or Residential Treatment Center which is duly licensed in the State of California to provide either acute inpatient

treatment, day treatment or outpatient care for the diagnosis and/or treatment of Mental Disorders and/or **Substance-Related and Addictive Disorder**, and which has entered into a written agreement with USBHPC.

Participating Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California and who has entered into a written agreement with USBHPC to provide Behavioral Health Services to Members.

Participating Providers. Participating Practitioners, Participating Preferred Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with USBHPC to provide Behavioral Health Services to Members.

Participating Group Practice. A Provider group or independent practice association duly organized and licensed under the laws of the State of California to provide Behavioral Health Services through agreements with individual behavioral health care Providers, each of whom is qualified and appropriately licensed to practice his or her profession in the State of California.

Participating Qualified Autism Service Provider - either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
- A person licensed as a Physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, or as authorized under California law, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

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

- Provides Behavioral Health Treatment.
- Is employed and supervised by a Participating Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code or is otherwise authorized under California law.

Participating Qualified Autism Service Paraprofessional - an unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is employed and supervised by a Participating Qualified Autism Service Provider.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.

- Has adequate education, training, and experience, as certified by a Participating Qualified Autism Service Provider.

Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California.

Premiums. The periodic, fixed-dollar amount payable to USBHPC by the Employer Group for or on behalf of the Subscriber and the Subscriber's eligible Dependents in consideration of Behavioral Health Services provided under this Plan.

Psychiatric Emergency Medical Condition. A mental disorder 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.

Residential Treatment Center. A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions and which is licensed, certified or approved as such by the appropriate state agency.

Schedule of Benefits. The schedule of Behavioral Health Services which is provided to a Members under this Behavioral Health Plan. The *Schedule of Benefits* is attached and incorporated in full and made a part of this document.

Serious Emotional Disturbance of a Child (SED) Under Age 18. A Serious Emotional Disturbance of a Child under Age 18 means a condition identified as a Mental Disorder in the DSM IV, other than a primary substance-related and addictive disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

- As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either:
  - (i) the child is at risk of removal from home or has already been removed from the home; or
  - (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays psychotic features or risk of suicide or violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Service Area. The geographic area in which USBHPC is licensed to arrange for Behavioral Health Services in the State of California by the California Department of Managed Health Care.

Severe Mental Illness (SMI). Severe Mental Illness includes the diagnosis and treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.

- Schizoaffective Disorder
- Schizophrenia

Spouse. The Subscriber's legally recognized husband or wife under the laws of the State of California.

Subscriber. The person whose employment or other status except for being a Family Member, is the basis for eligibility to enroll in the USBHPC Behavioral Health Plan and who meets all the applicable eligibility requirements of the Group and USBHPC and for whom Plan Premiums have been received by USBHPC.

Substance-Related and Addictive Disorder. An addictive relationship between a Member and any drug, alcohol or chemical substance that can be documented according to the criteria in the *DSM-IV-TR*. **Substance-Related and Addictive Disorder** does not include addiction to or dependency on (1) tobacco in any form or (2) food substances in any form.

Substance-Related and Addictive Disorder Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of **Substance-Related and Addictive Disorder**.

Substance-Related and Addictive Disorder Services. Medically Necessary services provided for the diagnosis and treatment of **Substance-Related and Addictive Disorder**.

Telehealth. The mode of delivering Covered Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Totally Disabled or Total Disability. The persistent inability to engage reliably in any substantially gainful activity by reason of any determinable physical or mental impairment resulting from an injury or illness. Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of a medically determinable physical or mental impairment resulting from an injury or illness. The disability must be related to a Behavioral Health condition, as defined in the *Diagnostic and Statistical Manual* current edition, in order to qualify for coverage under this USBHPC Plan. Determination of Total Disability shall be made by a USBHPC Participating Provider based upon a comprehensive psychiatric examination of the Member or upon the concurrence by a USBHPC Medical Director, if on the basis of a comprehensive psychiatric examination by a non-USBHPC Participating Provider.

Transitional Residential Recovery Services. Substance-Related and Addictive Disorder or chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

Treatment Plan. A structured course of treatment authorized by a USBHPC Clinician, when appropriate and for which a Member has been admitted to a Participating Facility, received Behavioral Health Services, and been discharged.

Urgent or Urgently Needed Services. Medically Necessary Behavioral Health Services received in an urgent care facility or in a Provider's office for an unforeseen condition to prevent serious deterioration of a Member's health resulting from an unforeseen illness or complication of an existing condition manifesting itself by acute symptoms of sufficient severity, such that treatment cannot be delayed.

USBHPC Clinician. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child therapist, nurse or other licensed health care professional with appropriate training and experience in Behavioral Health Services who is employed or under contract with USBHPC to perform case management services.

Visit. An outpatient session with a USBHPC Participating Practitioner conducted on an individual or group basis during which Behavioral Health Services are delivered.

NOTE: IN ORDER TO FULLY UNDERSTAND YOUR BENEFIT PLAN, THIS USBHPC *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* IS TO BE USED IN CONJUNCTION WITH YOUR UNITEDHEALTHCARE OF CALIFORNIA MEDICAL PLAN *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.* PLEASE READ BOTH DOCUMENTS CAREFULLY.

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

Benefit Plan:

$15 Copayment per Visit

20 Visit Annual Combined Maximum Benefit

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

How to Use the Program

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

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

Annual Benefits

Benefits include chiropractic and acupuncture services that are medically necessary services rendered by a participating provider. Treatment is to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome and to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Maximum Benefit Limits

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

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

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

Provider Eligibility

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

Types of Covered Services

Chiropractic Services:

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

2. Subsequent office visits, as set forth the treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.
3. Adjunctive therapy, as set forth the treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.
4. A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.
5. X-rays and laboratory tests are a covered benefit in order to examine any aspect of the member's condition.
6. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by the participating chiropractor.

Acupuncture Services

1. An initial examination is performed by the participating acupuncturist to determine medically necessary services to the extent consistent with professionally recognized standards of practice. At that time, a treatment plan of services will be provided. The initial examination will be provided to a member if the member seeks services from a participating acupuncturist for any injury, illness, disease, functional disorder or condition. A copayment will be required for such examination.
2. Subsequent office visits, as set forth in the treatment plan, may involve acupuncture treatment, a brief re-examination and/or a combination of services. A copayment will be required for each office visit.
3. A re-examination may be performed by the participating acupuncturist to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

Important OptumHealth Addresses:

Member Correspondence

OptumHealth of California, Inc.
Attn.: Member Correspondence Unit
P.O. Box 880009
San Diego, CA 92168-0009

Grievances and Complaints

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

Exclusions and Limitations

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

1. Any accommodation, service, supply or other item determined by health plan not to be medically necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-medically necessary purposes, and related expenses for reports, including report presentation and preparation;
4. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
5. Experimental or investigative services unless required by an external, independent review panel as described in 16.5 of the EOC;
6. Services provided at a hospital or other facility outside of a participating provider's facility;
7. Holistic or homeopathic care including drugs and ecological or environmental medicine;
8. Services involving the use of herbs and herbal remedies;
9. Treatment for asthma or addiction (including but not limited to smoking cessation);

10. Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;
11. Transportation to and from a provider;
12. Drugs or medicines;
13. Intravenous injections or solutions;
14. Charges for services provided by a provider to his or her family member(s);
15. Charges for care or services provided before the effective date of the member's coverage under the Group Enrollment Agreement or after the termination of the member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
16. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
17. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;
18. Claims by providers who or which are not participating providers, except for claims for out-of-network emergency services or urgent services, or other services authorized by health plan;
19. Ambulance services;
20. Surgical services;
21. Services relating to member education (including occupational or educational therapy) for a problem not associated with a chiropractic disorder or acupuncture disorder, unless supplied by the provider at no additional charge to the member or to health plan;
22. Non-urgent services performed by a provider who is a relative of the member by birth or marriage, including spouse or domestic partner, brother, sister, parent or child; and
23. Emergency services. If a Member believes he or she requires emergency services, the member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment**.** Medical emergencies are covered separately by the member's medical plan.

COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM
ACUPUNCTURE AND CHIROPRACTIC HEALTH BENEFITS PLAN

This "*Combined Evidence Of Coverage and Disclosure Form*" discloses the terms and conditions of coverage. However, it constitutes only a summary of your acupuncture and chiropractic health benefits plan. The document entitled "Group Enrollment Agreement" must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Group Enrollment Agreement will be furnished upon request. You have the right to review this *Combined Evidence Of Coverage and Disclosure Form* prior to enrollment. If you have special health care needs, review this *Combined Evidence Of Coverage and Disclosure Form* completely and carefully to determine if this benefit provides coverage for your special needs.

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

INTRODUCTION

This document describes the terms under which ACN Group of California, Inc. *dba OptumHealth Physical Health of California* will provide an acupuncture and chiropractic benefits program to employees of **Employer Group** and their Family Dependents who have enrolled under the Group Enrollment Agreement between *OptumHealth Physical Health of California* and **Employer Group.**

Throughout this document, *OptumHealth Physical Health of California* will be referred to as the "Health Plan," **Employer Group** will be referred to as the "Group," and enrollees under the Group Enrollment Agreement will be referred to as "Members." Along with reading this publication, be sure to review the *Schedule of Benefits* and any benefit materials. The *Schedule of Benefits* provides the details of this particular Health Plan, including any Copayments that a member may have to pay when using a health care service. Together, these documents explain this coverage.

SECTION 1. DEFINITIONS

This Section defines some important words and phrases that are used throughout this document. Understanding the meanings of these words and phrases is essential to an understanding of the overall document.

1.1 Acupuncture Disorder

"Acupuncture Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders or other conditions wherein Acupuncture Services can reasonably be anticipated to result in improvement.

1.2 Acupuncture Services

Covered 1.3 Acupuncturist

"Acupuncturist" means an individual duly licensed to practice acupuncture in California.

1.4 Annual Benefit Maximum

"Annual Benefit Maximum" means an amount specified in the *Schedule of Benefits* which is the maximum amount that Health Plan is obligated to pay on behalf of a Subscriber for Covered Services of a particular type or category provided to a Subscriber in a given benefit year.

1.5 Chiropractic Disorder

"Chiropractic Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders, wherein Chiropractic Services can reasonably be anticipated to result in improvement.

1.6 Chiropractic Services

"Chiropractic Services" means Medically Necessary services and supplies provided by or under the direction of a Participating Provider for the diagnosis of treatment of Chiropractic Disorders.

1.7 Chiropractor

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

1.8 Copayment

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

1.9 Coverage Decision

"Coverage Decision" means the approval or denial of benefits for health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a Disputed Health Care Service.

1.10 Covered Services

"Covered Services" means those Urgent Services, including chiropractic and acupuncture services that are medically necessary services rendered by a participating provider. Treatment is to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome and to reduce pain and improve functioning of the neuromusculoskeletal system to which Members are entitled under the terms of the Group Enrollment Agreement and this *Combined Evidence Of Coverage and Disclosure Form*, as such documents may be amended from time to time in accordance with their terms.

1.11 Department

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

1.12 Disputed Health Care Service

"Disputed Health Care Service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not Medically Necessary.

1.13 Domestic Partner

"Domestic Partner" means a person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is eighteen (18) years of age or older;
- Is mentally competent to consent to contract;
- Resides with the Subscriber and intends to do so indefinitely;
- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

1.14 Emergency Services

"Emergency Services" means services provided for a medical condition (including a psychiatric medical condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part.

1.15 Exclusion

"Exclusion" means any service, equipment, supply, accommodation or other item specifically listed or described as excluded in the Group Enrollment Agreement or this *Combined Evidence Of Coverage and Disclosure Form*.

1.16 Family Dependent

"Family Dependent" means an individual who is a member of a Subscriber's family and who is eligible and enrolled in accordance with all applicable requirements of the Group Enrollment Agreement, and on whose behalf Health Plan has received premiums.

1.17 Group Enrollment Agreement

"Group Enrollment Agreement" means the agreement entered into by and between ACN Group of California, Inc. of California and Group through which you enroll for coverage.

1.18 Limitation

"Limitation" means any provision, other than an Exclusion, contained in the Group Enrollment Agreement, this *Combined Evidence Of Coverage and Disclosure Form* or the attached *Schedule of Benefits*, which limit the covered Chiropractic Services or Acupuncture Services to which Members are entitled.

1.19 Medically Necessary

"Medically Necessary" means:

"Services rendered by a participating provider. Treatment is to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome and to reduce pain and improve functioning of the neuromusculoskeletal system."

1.20 Member

"Member" means a Subscriber or a Family Dependent.

1.21 Negotiated Rates Schedule

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

1.22 Neuromusculoskeletal Disorders

"Neuromusculoskeletal Disorders" means conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction is the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related to neurological manifestations or conditions.

1.23 Participating Provider

"Participating Provider" means any Chiropractor or Acupuncturist who is qualified and duly licensed or certified by the State of California to furnish Chiropractic Services or Acupuncture Services and has entered into a contract with the Health Plan to provide Covered Services to Members.

1.24 *Schedule of Benefits*

"*Schedule of Benefits*" means the summary of Copayments, Annual Benefit Maximums, Exclusions and Limitations applicable to Member's chiropractic and acupuncture benefits program. The *Schedule of Benefits* is Attachment A to this *Combined Evidence Of Coverage and Disclosure Form*.

1.25 Subscriber

"Subscriber" means an employee or retiree who is eligible and enrolled in accordance with all applicable requirements of this Agreement, and on whose behalf the Group has made premium payments.

1.26 Urgent Services

"Urgent Services" means services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

SECTION 2. RENEWAL PROVISIONS

After the Initial Term, the Group Enrollment Agreement will automatically renew from year to year for additional twelve (12)-month periods ("Subsequent Terms") on the same terms and conditions unless terminated by the Group in accordance with Section 22 of the Group Enrollment Agreement. However, Health Plan has reserved the right to change the Premium Rate Schedule in accordance with Section 5.4 of the Group Enrollment Agreement and any other term or condition of the Group Enrollment Agreement upon thirty-one (31) days' prior written notice to the Group.

SECTION 3. PRINCIPAL BENEFITS AND COVERAGES

Members are entitled to receive the Covered Services described in this Section when such services are Medically Necessary for the treatment of a Member's Chiropractic Disorder or Acupuncture Disorder, subject to all applicable Exclusions and Limitations and Benefit Maximums, as well as all other terms and conditions contained in this Combined Evidence Of Coverage and Disclosure Form and the Group Enrollment Agreement.

3.1 Chiropractic Services Description

Chiropractic Services provided include:

(A) Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system;

(B) Initial patient examinations;

(C) Subsequent visits for further evaluation of a Member's condition;

(D) Adjunctive therapies, such as ultrasound, hot/cold packs, electrical muscle stimulation, and other therapies;

(E) Examination of any aspect of the Member's condition by means of radiological (x-ray) diagnostic imaging or clinical laboratory tests;

(F) Spinal and Extraspinal Treatment; and

(G) Durable Medical Equipment (limited to $50 per year).*

3.2 Acupuncture Services Description

Acupuncture Services provided include:

(A) Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions;

(B) Initial patient examinations;

(C) Subsequent visits for further evaluation of a Member's condition; and

(D) Adjunctive therapies such as moxibustion, cupping and acupressure.

3.3 Urgent Services

Urgent Services are services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed. Members are entitled to receive Urgent Services, including Urgent Services received outside the Health Plan's service area, when such services are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

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* **Durable Medical Equipment or DME** means equipment that can withstand repeated use by Members outside a provider's office or facility, is primarily or customarily used in the treatment of Chiropractic Disorders, and is generally not useful to a Member in the absence of a Chiropractic Disorder. Members should refer to the *Schedule of Benefits* at Attachment A for a description of the DME covered under the benefit plan, and Section 9.2 for a description of the limitations applicable to DME.

3.4 Emergency Services

If a Member believes he or she requires Emergency Services as defined in Section 1.14, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Members are encouraged to use appropriately the 911 emergency response system, in areas where the system is established and operating, when they have an emergency condition that requires an emergency response.

3.5 Second Opinions

Where, as a result of a Chiropractic Disorder or Acupuncture Disorder, a treatment plan is recommended by a Participating Provider, Health Plan, Member or the treating Provider on a Member's behalf, may request that a second opinion be obtained from a Participating Provider qualified to diagnose and treat the specific Chiropractic Disorder or Acupuncture Disorder.

3.5.1 Second Opinion Requests

A Member may request a second opinion when the Member has concerns that may include, but are not be limited to, any of the following:

(A) The Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to a serious chronic condition;

(B) The Member finds that the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating chiropractic or acupuncture health professional is unable to diagnose the condition;

(C) The Member determines that the treatment plan in progress is not improving the chiropractic or acupuncture health condition of the Member within an appropriate period of time given the diagnosis and plan of care; or

(D) The Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Members may request a second opinion by contacting Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

When the request originates with the Member and concerns care from a Participating Provider, a second opinion is to be provided by any provider of the Member's choice from within the Health Plan's network. The provider must be of the same or equivalent specialty, acting within his or her scope of practice and possess clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for the second opinion.

If there is no Participating Provider within the network who meets the standard specified above, then the Health Plan shall authorize a second opinion by an appropriately qualified health professional outside of the Health Plan's provider network.

All second opinions requested or certified by Health Plan, including all related diagnostic tests, are Covered Services. If Health Plan approves a Member request for a second opinion, the Health Plan shall be responsible for the costs of such opinion. The Member shall be responsible only for the costs of applicable Copayments that the Health Plan requires for similar referrals.

If an out-of-plan second opinion is authorized by the Health Plan, the Member's Copayment will be the same as the in-network Copayment payable to the same type of provider.

A second opinion authorized by the Health Plan shall not count against the Member's benefit limitation. Unless specifically authorized by the Health Plan, any **additional** medical opinions not within the contracted network shall be the responsibility of the Member.

3.5.2 Plan Review of Requests for Second Opinions

Health Plan's authorization or denial of a request for a second opinion shall be provided in an expeditious manner. All non-urgent requests will be resolved within 72 hours of the Health Plan's receipt of a request for a second opinion.

An urgent request, when the Member's condition is such that the Member faces an imminent or serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental to the Member's ability to regain maximum function, will be expedited and resolved (authorized or denied) whenever possible within 24 hours but not to exceed 72 hours from the Plan's receipt of the request.

The Health Plan will deny a Member's request for a second opinion only in the absence of applicable benefits. In any such case, the Health Plan shall notify the Member in writing of the reasons for the denial and shall inform the Member of the right to file a grievance with the Health Plan.

A copy of the Health Plan's Policy and Procedure regarding second opinions is available to Members and the public upon request. Members may request a copy of the Policy and Procedure by contacting the Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

3.6 Continuity of Care

Upon a Member's request, Health Plan will provide for the completion of Covered Services that are being rendered by a Terminated Provider or a Non-Contracting Provider when the Member is receiving services from that provider for an "acute condition," a "serious chronic condition," or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage, or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates. Members who wish to request continuity of care coverage or a copy of Health Plan's Policy and Procedure regarding continuity of care should contact the Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*, or by writing to the Customer Services Department at the following address:

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

Members may also fax their questions or requests to Health Plan at (619) 641-7185, or contact Health Plan online at www.myoptumhealthphysicalhealthofca.com.

If a Member requests to keep their provider, they should include in the request the name of the provider, the provider's contact information, and information regarding the condition for which the Member is receiving care from the provider.

After Health Plan has received all information necessary, Health Plan will complete its review in a timely manner appropriate for the nature of the Member's clinical condition. Health Plan will mail the Member a written notification of its decision within five (5) business days of its decision.

Except as otherwise provided by applicable law:

3.6.1 Health Plan shall, at the request of a Member, provide for continuity of care for the Member by a Terminated Provider or by a Non-Contracting Provider who has been providing care for an acute condition, a serious chronic condition, or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates.

3.6.2 In cases involving an acute condition, Health Plan shall furnish the Member with Covered Services for the duration of the acute condition.

3.6.3 In cases involving a serious chronic condition, Health Plan shall furnish the Member with Covered Services for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Participating Provider as determined by Health Plan in consultation with the terminated provider, consistent with good professional practice.

3.6.4 In cases involving the care of a newborn child between birth and age 36 months, completion of Covered Services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.

3.6.5 The payment of any Copayments by the Member during the period of continuation of care shall be the same any Copayments that would be paid by the Member when receiving Covered Services from a Participating Provider.

3.6.6 **Definitions.** For purposes of this Section 8.6, the following definitions will apply:

3.6.6.1 **"**Acute condition" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

3.6.6.2 "Serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

3.6.6.3 **"**Provider" is an acupuncturist or chiropractor duly licensed under California law to deliver or furnish acupuncture or chiropractic services.

3.6.6.4 "Participating Provider" has the same meaning as stated in Section 1.23 of this *Combined Evidence Of Coverage and Disclosure Form*.

3.6.6.5 "Non-Contracting Provider" is a Provider who is not party to a contract with the Plan to provide acupuncture or chiropractic services.

3.6.6.6 "Terminated Provider" is a Provider whose contract with the Plan has terminated or has not been renewed.

3.6.7 **Terminated Providers.** In the event the criteria listed in the continuity of care section (8.5) are met; Health Plan will require a Terminated Provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that applied to the provider prior to termination, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Terminated Provider does not agree to comply or does not comply with these contractual terms and conditions, Health Plan will not continue the Terminated Provider's services beyond the contract termination date. In such cases, Health Plan will refer the Member to a Participating Provider.

Unless otherwise agreed by the Terminated Provider and Health Plan, the services rendered shall be compensated at rates and methods of payment similar to those used by Health Plan for Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Terminated Provider. Health Plan will not continue the services of a Terminated Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 8.6.7. In such cases, Health Plan will refer the Member to a Participating Provider.

3.6.8 Non-Contracting Providers. In the event the criteria listed in the continuity of care section (8.5) are met; Health Plan will allow a Non-Contracted Provider to treat a Member, as long as the provider agrees in writing to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Non-Contracting Provider, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Non-Contracting Provider does not agree to comply or does not comply with these contractual terms and conditions, Health Plan will not continue the provider's services. In such cases, Health Plan will refer the Member to a Participating Provider.

Unless otherwise agreed upon by the Non-Contracting Provider and Health Plan, the services rendered shall be compensated at rates and methods of payment similar to those used by Health Plan for Participating Providers providing similar services who are practicing in the same or a similar geographic area as the Non-Contracting Provider. Health Plan will not continue the services of a Non-Contracted Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 8.6.8. In such cases, Health Plan will refer the Member to a Participating Provider.

3.6.9 Limitations. Members are not eligible to keep their provider if the provider does not agree to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as your provider. Members are not eligible to keep their provider if their provider had a contract with Health Plan which was terminated or not renewed for reasons relating to a medical disciplinary cause or reason, fraud, or other criminal activity. New Members are not eligible to keep their provider if the Member had the option to continue with another health plan or provider and voluntarily chose to change health plans. In each of these cases, Health Plan will refer the Member to a Participating Provider. Health Plan will not cover services that are not otherwise covered under a Member's benefit plan.

3.6.10 If a Member is not satisfied with Health Plan's decision, a Member may file a grievance with the Health Plan subject to the terms and instructions included at Section 15 of this *Combined Evidence Of Coverage and Disclosure Form*.

3.7 Facilities

During Health Plan's business hours (Monday through Friday, 8:30 a.m. through 5:00 p.m.) services provided through Health Plan's 24-hour toll-free telephone number referenced in Section 15.3 include referral of Members for Covered Services and responding to Member inquiries and questions regarding Covered Services. After hours, Health Plan will maintain an answering service with recorded instructions for members who call after-hours.

Health Plan: (i) maintains an after-hours answering service with recorded instructions for members who call after-hours, and (ii) requires its Participating Providers to provide Members with telephone access to a Participating Provider twenty-four (24) hours a day, seven (7) days a week**.**

Participating Providers must be available for office hours during normal business hours (generally Monday through Friday between 9:00 a.m. and 5:00 p.m.). Members may obtain office hours and emergency information from a Participating Provider's answering machine any time staff is not able to answer the phone. Members may also leave a message twenty-four (24) hours a day.

3.8 Access to Care Guidelines

Health Plan ensures that Members, during normal business hours, can speak to a customer service representative and will not have a waiting time that exceeds ten (10) minutes. Health Plan's standards for access to care from the time of the request of an appointment from a member are as follows:

Type of Care	Timing

Urgent Care	Within 24 hours
Routine care	Within ten (10) business days
Urgent Patient calls	Returned within 30 minutes

SECTION 4. PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

4.1 Exclusions

The following accommodations, services, supplies and other items are specifically excluded from coverage:

(A) Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;

(B) Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;

(C) Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care.

(D) Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;

(E) Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;

(F) Experimental or investigative services unless required by an external, independent review panel as described in Section 16.5;

(G) Services provided at a hospital or other facility outside of a Participating Provider's facility;

(H) Holistic or homeopathic care including drugs and ecological or environmental medicine;

(I) Services involving the use of herbs and herbal remedies;

(J) Treatment for asthma or addiction (including but not limited to smoking cessation);

(K) Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;

(L) Transportation to and from a provider;

(M) Drugs or medicines;

(N) Intravenous injections or solutions;

(O) Charges for services provided by a Provider to his or her family Member(s);

(P) Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;

(Q) Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;

(R) Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;

(S) Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services Urgent Services, or other services authorized by Health Plan;

(T) Ambulance services;

(U) Surgical services;

(V) Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder or Acupuncture Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;

(W) Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child;

(X) Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Medical Emergencies are covered by the Member's medical plan rather than OptumHealth Physical Health of California

4.2 Limitations

The *Schedule of Benefits* attached as Attachment A lists the Copayments and Annual Benefit Maximums that are applicable to, and that operate as Limitations on, Covered Services. Coverage for Durable Medical Equipment is limited to $50 per year.

SECTION 5. CHOICE OF PROVIDERS

5.1 Access to Participating Provider

Each Member who requests that Covered Services be provided will be able to choose from any Health Plan Participating Provider who will coordinate the Covered Services to be received by the Member. Members may request access to a Participating Provider by contacting Health Plan's Customer Services department at the toll-free telephone number printed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

5.2 Liability of Member for Payment

If a Member chooses to obtain out-of-network Chiropractic Services or Acupuncture Services (other than Urgent Services) from a provider other than a Participating Provider, the Member will be liable for payment for such services. **Services (other than Urgent Services) performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child are not covered.**

SECTION 6. COORDINATION OF BENEFITS (COB)

6.1 The Purpose of COB

The provisions of this Section establish a procedure through which Health Plan or a Participating Provider may, in certain instances, recover a portion of the costs of Covered Services from an insurer or other third-party payor which also provides indemnity or other coverage for Chiropractic Services or Acupuncture Services provided to a Member. The Group and all Members shall cooperate with Health Plan in the administration of these provisions.

6.2 Benefits Subject to COB

All of the benefits provided under this Agreement are subject to COB in accordance with the provisions of this Section 11.

6.3 Definitions

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

6.3.1 "Plan" means any plan providing chiropractic and acupuncture benefits for, or by reason of, Chiropractic Services and Acupuncture Services, which benefits are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs other than Medi-Cal, or California Children's Services, and any coverage required or provided by any statute.

6.3.2 The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

6.3.2.1 The term "Plan" shall include:

6.3.2.1.1 All group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to Section 10270.97 of the California Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to 10270.2(b) or (e) which contain non-duplication of benefits or excess policy provisions.

6.3.2.1.2 "Medicare" or other similar governmental benefits, provided that:

(A) The definition of "Allowable Expenses" shall only include the chiropractic and acupuncture benefits as may be provided by the governmental program;

(B) Such benefits are not by law excess to this Plan; and

(C) The inclusion of such benefits is inconsistent with any other provision of this Agreement.

6.3.2.1.3 The term "Plan" shall not include:

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

6.3.2.1.3.2 Any entitlements to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the California Welfare and Institutions Code, or benefits under the California

Children's Services under Section 10020 of the Welfare and Institutions Code, or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.

6.3.2.1.3.3 Medical payment benefits customarily included in traditional automobile contracts.

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

6.3.4 "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and benefit paid.

6.3.5 "Claim Determination Period" means a calendar year.

6.4 Effect on Benefits

6.4.1 This Section 11 shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:

6.4.1.1 The value of the benefits that would be provided by this Plan in the absence of this Section 11, and

6.4.1.2 The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

6.4.2 As to any Claim Determination Period to which this Section is applicable, the benefits that would be provided under this Plan in the absence of this provision for Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in Section 11.4.3 immediately below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefore.

6.4.3 If another Plan which is involved in Section 11.4.2 immediately above and which contains: provisions coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and the rules set forth in Section 11.5 immediately below would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

6.5 Rules Establishing Order of Determination

For the purpose of Section 11.4, the rules establishing the order of determination are:

6.5.1 The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as dependent.

6.5.2 Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as

dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of the benefits.

6.5.3 In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

6.5.4 In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as dependent of the parent without custody.

6.5.5 In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced where there is a court decree which would otherwise establish financial responsibility for the costs of Chiropractic Services or Acupuncture Services with respect to the child, then, notwithstanding Sections 11.5.3 and 11.5.4, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

6.5.6 When Sections 11.5.1 through 11.5.5 do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

6.5.6.1 The benefits of a Plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

6.5.6.2 If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining benefits after the other, then Section 11.5.6.1 shall not apply.

In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this provision.

If a claimant's effective date of coverage under a given Plan is subsequent to the date the other carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this provision, that the claimant's length of time covered under the Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of

any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his or her coverage under that Plan has been in force.

6.6 Reduction of Benefits

When this Section 11 operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan. Health Plan may not decrease, in any manner, the benefits stated herein, except after a period of at least thirty (30) days from the date of the postage paid mailing to the Group.

6.7 Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section 11 of this Plan or any provision of similar purpose of any other Plan, to the extent permitted by applicable law, including the Health Insurance Portability and Accountability Act of 1996 and the Confidentiality of Medical Information Act, the Plan may release to or obtain from any insurance Health Plan or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

6.8 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

6.9 Right of Recovery

Whenever payments have been made by the Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Section 11, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to, for, or with respect to whom such payments were made, any insurers, any service plans, or any other organizations.

SECTION 7. THIRD-PARTY LIABILITY

7.1 Member Reimbursement Obligation

If a Member receives payment by way of a third-party suit or settlement for Covered Services provided or paid for by Health Plan, the Member shall be obligated to reimburse Health Plan for the actual costs incurred by Health Plan for such Covered Services, but no more than the amount the Member recovers on account of the condition for which Covered Services were provided, exclusive of any amounts awarded in a suit as compensatory damages for any items other than the expenses of Chiropractic Services and Acupuncture Services and any amounts awarded as punitive damages.

7.2 Health Plan's Right of Recovery

Health Plan shall have a lien on all funds recovered by a Member from a third party pursuant to Section 12.1 immediately above. Such lien shall not exceed the sum of the reasonable costs actually paid by Health Plan to perfect the lien and the amount actually paid by Health Plan to any treating provider. If the Member engaged an attorney, the lien may not exceed one-third (1/3) of the monies due to the Member under any final judgment, compromise, or settlement agreement. If the Member did not engage an attorney, the lien may not exceed one-half (1/2) of the monies due to the Member under any final judgment, compromise, or settlement agreement. Health Plan may give notice of such lien to any party who may have contributed to the loss.

7.3 Member Cooperation

The Member shall take such action, furnish such information (including responding to requests for information about any accident or injuries and making court appearances) and assistance, and execute such instruments (including a written confirmation of assignment, and consent to release medical records) as Health Plan may require to facilitate enforcement of Health Plan's rights under this Section 12, and shall take no action that tends to prejudice such rights. Any Member who fails to cooperate in Health Plan's administration of this Section 12 shall be responsible for the amount otherwise recoverable by Health Plan under this Section.

7.4 Subrogation Limitation

Health Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, from any or all of the following:

(A) Third parties, including any person alleged to have caused Member to suffer injuries or damages;

(B) Member's employer;

(C) Any person or entity obligated to provide benefits or payments to Member, including benefits or payments for underinsured or uninsured motorist protection (collectively referred to as "Third Parties.")

Health Plan has the right to be subrogated to the Member's rights for all amounts recoverable by Health Plan under this Section 12. Health Plan's rights under this Section 12.4 include the right to bring suit against the third party in the Member's name.

Member agrees:

(A) To assign all rights of recovery against Third Parties, to the extent of the actual costs of Covered Services provided or paid for by Health Plan, plus reasonable costs of collection;

(B) To cooperate with Health Plan in protecting Health Plan's legal rights to subrogation and reimbursement;

(C) That Health Plan's rights will be considered as the first priority claim against Third Parties, to be paid before any other of Member's claims are paid;

(D) That Member will do nothing to prejudice Health Plan's rights under this provision, either before or after the need for services or benefits under this document;

(E) That Health Plan may, at Health Plan's option, take necessary and appropriate action to preserve Health Plan's rights under these subrogation provisions, including filing suit in Member's name;

(F) That regardless of whether or not Member has been fully compensated, Health Plan may collect from the proceeds of any full or partial recovery that Member or Member's legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the actual costs incurred by Health Plan for Covered Services provided or paid for by Health Plan;

(G) To hold in trust for Health Plan's benefit under these subrogation provisions any proceeds of settlement or judgment;

(H) That Health Plan shall be entitled to recover from Member reasonable attorney fees incurred in collecting proceeds held by Member;

(I) That Member will not accept any settlement that does not fully compensate or reimburse Health Plan without Health Plan's written approval.

SECTION 8. MANAGED CARE PROGRAM

8.1 Managed Care Program

The Managed Care Program is the program by which Health Plan determines whether services or other items are Medically Necessary and directs care in the most cost-efficient manner. The Managed Care Program includes, but is not limited to, requirements with respect to the following: concurrent and retrospective utilization review; and quality assurance activities. The Managed Care Program requires the cooperation of Members, Participating Providers, and Health Plan. All Participating Providers have agreed to participate in Health Plan's Managed Care Program.

8.2 Managed Care Process

Health Plan's Utilization Management Committees will have program oversight for Chiropractic Services and Acupuncture Services provided, or to be provided, to Members under this Agreement in order to determine: (i) whether the services are/were Medically Necessary; (ii) the appropriateness of the recommended treatment setting; (iii) the required duration of treatment; (iv) whether the recommended treatment qualifies as a Covered Service; and (v) whether any Limitations apply.

8.3 Appeal Rights

All decisions made by Health Plan in connection with the Managed Care Program may be appealed by the Member through the Grievance Procedure set forth in Section 16.

8.4 Utilization Management

Health Plan utilizes the following process to authorize, modify, or deny services under benefits provided by the Health Plan.

8.4.1 **Utilization Review**. Utilization review occurs as the services are provided (concurrent), or after the services have been provided (retrospective). The Utilization Review Process requires health care providers to submit the authorization request forms. Utilization review will not be conducted more frequently than is reasonably required to assess whether the health care services under review meet plan benefit coverage criteria. The provider is responsible for documenting the medical necessity of services through the authorization process.

8.4.2 **Benefit Coverage Determinations.** Benefit coverage determinations are made by the Health Plan's Support Clinicians based upon your benefit plan and may include an adverse determination due to a limitation in benefit coverage or an exclusion of benefit coverage. These are not medical necessity determinations.

8.4.3 **Support Clinicians/Clinical Peer Reviewers.** All clinical reviews are conducted by licensed peer reviewers who meet the Health Plan provider credentialing process and possess the additional qualifications.

8.4.4 **Member Disclosure**. The process used by Health Plan to authorize, modify, or deny health care services under any benefit plan will be disclosed to members or their designees upon request.

8.4.5 **Notifications and Time Frames.** Unless specific state or federal law requires other time frame and notification standards, the following will apply for Health Plan's utilization management determinations.

8.4.5.1 Health Plan uses one standard process that applies to both concurrent and retrospective review. The Support Clinician completes the concurrent review process within five (5) business days of receipt of all necessary information. Retrospective reviews are completed within thirty (30) business days of receipt of all necessary information.

8.4.5.2 An Authorization Response is sent to the provider and Enrollee indicating the Support Clinician's decision within one (1) business day of the date of decision. The written response is sent to the provider by U.S. Mail. Written notification is sent to the Enrollee by U.S. Mail.

8.4.5.3 The Authorization Response sent to the provider and the Enrollee includes messages addressing any changes to the requested treatment plan. In addition, each response to the provider includes the name of the Support Clinician and instructions and timelines for the submission of missing or additional documentation.

8.4.5.4 If Health Plan cannot make a decision to approve, modify or deny a request for authorization within the time frames specified above because Health Plan is not in receipt of all of the information reasonably necessary and requested, or because Health Plan requires consultation by an expert reviewer, or because Health Plan has asked that an additional examination or test be performed upon the member (provided the examination or test is reasonable and consistent with good medical practice in the organized chiropractic community), Health Plan shall, immediately upon the expiration of the specified time frame, or as soon as Health Plan becomes aware that it will not meet the time frame, whichever occurs first, notify the provider and the member, in writing, that Health Plan cannot make a decision to approve, modify, or deny the request for authorization within the required time frame, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. Health Plan shall also notify the provider and the member of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested, Health Plan will approve, modify, or deny the request for authorization within the applicable time frame specified above.

8.4.5.5 A request for services may be denied on the basis that information necessary to determine medical necessity was not received. If Health Plan requests medical information from a provider in order to determine whether to approve, modify, or deny a request for authorization, Health Plan will request only the information reasonably necessary to make the determination. A reasonable attempt to obtain the missing information from the enrollee's provider will be made prior to denying services based on lack of information. The request for the necessary information will be handled in accordance with Health Plan policy.

8.4.5.6 In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of Health Plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member.

8.4.6 Adverse Determinations. Unless specific state or federal law requires other time frame and notification standards, the following will apply for Health Plan's utilization management determinations.

8.4.6.1 An adverse determination by a Health Plan Support Clinician means one or more of the service(s) requested was determined to be not Medically Necessary or appropriate.

8.4.6.2 Clinical determinations are decisions made with regard to the provider's requested duration of care, quantity or services or types of services.

8.4.7 Nothing in this Section 13 shall be construed or applied to interfere with a Member's right to submit a grievance or seek an independent medical review in accordance with applicable law. Members shall in all cases have an opportunity to submit a grievance to Health Plan or seek an independent medical review whenever a health care service is denied, modified, or delayed by Health Plan, or

by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not Medically Necessary.

8.4.8 All grievances shall be handled in accordance with Health Plan's Grievance Resolution Policies and Procedures, as described in Section 16.

8.4.9 A request for an independent medical review shall be handled in accordance with Health Plan's policies and procedures on independent medical reviews or, if applicable, the policies and procedures on independent review of decisions regarding experimental or investigational therapies, as described in Section 16.5.

SECTION 9. REIMBURSEMENT PROVISIONS

Members may receive Covered Services under the Group Enrollment Agreement only from Participating Providers or as directed by the Health Plan. Claims for reimbursement for Covered Services received by a Member shall be submitted by the Participating Provider. The Member shall not be responsible for submitting claim forms for reimbursement of any Covered Services.

SECTION 10. RESPONSIBILITIES OF HEALTH PLAN

10.1 Arrangements for Covered Services

Health Plan will enter into arrangements with Participating Providers in order to make available to Members the Covered Services described in this document. Subject to Section 8.6, Health Plan makes no warranty or representation to the Group or to Members regarding the continued availability of any particular Participating Provider to a particular Member or to Members in general.

10.2 Compensation of Providers

Health Plan will be responsible for compensating Participating Providers for Covered Services provided to eligible Members in accordance with the requirements of any contract between Health Plan and the Participating Provider. As required by state law, all contracts between Health Plan and Participating Providers provide that, in the event Health Plan fails to pay the Participating Provider for Covered Services for which Health Plan is financially responsible, no Member shall be liable to the Participating Provider for Covered Services.

In the event that Health Plan fails to pay a provider who is not a Participating Provider for Covered Services for which Health Plan is financially responsible, the Member who received such services may be liable to the provider for the cost of the services.

10.3 Toll-Free Telephone Number

Health Plan will make available to Members a published toll-free telephone number to contact Health Plan. This telephone number is available to Members twenty-four hours a day, seven days a week.

10.4 Public Policy Committee

Health Plan's Public Policy Committee will participate in establishing public policy for Health Plan's chiropractic and acupuncture benefits programs including, but not limited to, the comfort, dignity and convenience of Members. Members are invited to participate in the Public Policy Committee and may write to the Chair of the Public Policy Committee at the address included on the cover of this document.

10.5 Notices to Group Representatives

Any notice given by Health Plan to the Group pursuant to the Group Enrollment Agreement may be given by Health Plan to the group representative designated by the Group pursuant to this Section 15.5.

10.6 Termination or Breach of a Participating Provider Contract

10.6.1 Health Plan shall provide Group written notice within 30 days of Health Plan's receipt of any Participating Provider's notice of termination or inability to perform its contract with Health Plan, or within 30 days of Health Plan's providing to any Participating Provider a notice of termination or uncured breach, if the Group or any Member may be materially and adversely affected by such termination, breach, or inability to perform.

10.6.2 In the event that a contract between Health Plan and a Participating Provider terminates while a Member is under the care of such Participating Provider, Health Plan will arrange for the provision of continuity of care services as described in Section 8.6.

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

SECTION 11. GRIEVANCE PROCEDURES

11.1 Applicability of the Grievance Procedures

All Member disputes and controversies arising under the Plan will be resolved pursuant to the Grievance Procedures set forth in this Section 16.

11.2 Grievances

Every Member has the right to communicate a grievance to Health Plan by calling the telephone number listed below, by submitting a written grievance to the address indicated below, by submitting a written grievance by facsimile or email, or by completing an online grievance form.

Grievance Coordinator
OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009
1-800-428-6337
(619) 641-7185 (Fax)
www.myoptumhealthphysicalhealthofca.com

Health Plan will acknowledge receipt of the grievance in writing for urgent issues on the day of receipt, and all routine grievances within five (5) calendar days of receipt. These deadlines do not apply to grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day.

If the grievance pertains to a Quality of Service issue, it may be investigated and resolved by the Health Plan in collaboration with any other involved departments. If the grievance pertains to a Quality of Care issue and is routine, the Health Plan transfers the information to the Medical Director. If the grievance pertains to a Quality of Care issue and is urgent, the Health Plan will promptly initiate the Expedited Review process.

Health Plan will provide a written statement on the determination of any grievance except for grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day. For an urgent grievance in which medical/clinical services are underway, Health Plan will notify the complainant and the Department within twenty-four (24) hours of the Health Plan's receipt of the grievance. For all other urgent grievances, Health Plan will notify the complainant and the Department within three (3) calendar days of the Health Plan's receipt of the grievance. For routine grievances, Health Plan will notify the complainant within five (5) calendar days of the Health Plan's receipt of the grievance.

Grievance forms and Health Plan’s grievance policies and procedures are available to Members upon request.

11.3 Expedited Review of Grievances

For Member grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, Health Plan shall immediately inform the Member, in writing, of the Member's right to notify the Department, and to provide the Member and the Department written notice of the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the grievances.

11.4 Independent Medical Review (IMR)

In the event the Member is dissatisfied with the findings and decision of Health Plan, the Member is not required to further participate in Health Plan’s grievance process thirty (30) days after Health Plan’s receipt of the complaint. The Member may request an Independent Medical Review (IMR) of Disputed Health Care Services from the Department if the Member believes that health care services have been improperly denied, modified, or

delayed by the Health Plan or one of its contracting providers. A “Disputed Health Care Service” is any health care service eligible for coverage and payment under the subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to the Member. The Member pays no application or processing fees of any kind for IMR. The Member has the right to provide information in support of the request for IMR. The Plan must provide the Member with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against the plan regarding the Disputed Health Care Service.

For more information regarding the IMR process, or to request an application form, please call Health Plan’s Customer Services department at 1-800-428-6337; or write to OptumHealth Physical Health of California at P.O. Box 880009, San Diego, CA
92168-0009.

11.5 Independent Medical Review (IMR) for Experimental and Investigational Therapies

You may also have the right to an independent medical review through the Department if the Health Plan denies coverage for a requested service on the basis that it is experimental or investigational. Health Plan will notify you within 5 business days of its decision to deny an experimental/investigational therapy. You are not required to participate in the Health Plan’s grievance process prior to seeking an independent medical review of this decision.

The Independent Medical Review Organization will complete its review within 30 days of receipt of your application and supporting documentation. If your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the review will be completed within 7 days.

11.6 Implementation of IMR Decision

If the Member receives a decision by the Director of the Department that a Disputed Health Care Service is Medically Necessary, Health Plan will promptly implement the decision.

In the case of reimbursement for services already provided, Health Plan will reimburse the provider or Member within five (5) working days. In the case of services not yet provided, Health Plan will authorize the services within five (5) working days of receipt of the written decision from the Director or sooner, if appropriate for the nature of the Member’s medical condition, and will inform the Member and Provider of the authorization according to the requirements of Health and Safety Code Section 1367.01(h)(3).

11.7 Exhaustion of Remedies

A Member shall not be entitled to maintain a cause of action alleging that Health Plan has failed to exercise ordinary care unless the Member or his or her representative has exhausted the procedures provided by IMR process, except in a case where either of the following applies: (i) substantial harm has occurred prior to the completion of the IMR process; or (ii) substantial harm will imminently occur prior to the completion of the IMR process. For purposes of this Section 16.7, substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.

11.8 Department Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-800-428-6337) or (1-619-641-7100) or for TTY/TDD services call 1-(888) 877-5379 (voice), or 1-(888) 877-5378 (TDDY)) and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been

satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) or (1-800-735-2929) for the hearing- and speech-impaired. The Department's Internet website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

SECTION 12. GENERAL INFORMATION

12.1 Relationship Between Health Plan and Each Participating Provider

The relationship between Health Plan and each Participating Provider is an independent contractor relationship. Participating Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an employee or agent of any Participating Provider. Health Plan will not be liable for any claims or demands on account of damages arising out of, or in any manner connected with, any injury suffered by a Member relating to Chiropractic Services or Acupuncture Services received by the Member from any Participating Provider.

12.2 Nondisclosure and Confidentiality

Neither Health Plan nor the Group shall release any information regarding the terms set forth in this Agreement to any person or entity without the prior written consent of the other, except such information as may be necessary to disclose to agents, affiliates, attorneys, accountants, governmental regulatory agencies, non-covered custodial parents of a covered children, or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law or provisions of the Agreement, Health Plan and the Group shall keep confidential, and shall take the usual precautions to prevent the unauthorized disclosure of any and all resources required to be prepared or maintained in accordance with this Agreement.

12.3 Overpayments

Member shall agree to reimburse Health Plan, on demand, any and all such amounts Health Plan pays to or on behalf of a Member:

(A) For services or accommodations which do not qualify as Covered Services;

(B) With respect to a Subscriber's family member or a person believed to be a Subscriber's family member, who is not entitled to Covered Services under the Group Enrollment Agreement; or

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

12.4 Confidentiality of Medical Records

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

12.5 Interpretation of Benefits

Subject to the Member grievance procedures specified in Section 16, Health Plan has the sole and exclusive discretion to do all of the following:

(A) Interpret benefits under the plan.

(B) Interpret the other terms, conditions, limitations and exclusions set out in the plan, including this document and any Amendments.

(C) Make factual determinations related to this document and benefits.

Health Plan may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the plan.

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

12.6 Administrative Services

Health Plan may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Health Plan's sole discretion. Health Plan is not required to give Member prior notice of any such change, nor is Health Plan required to obtain Member's approval. Member must cooperate with those persons or entities in the performance of their responsibilities.

12.7 Amendments to the Plan

To the extent permitted by law, Health Plan reserves the right, in Health Plan's sole discretion and without Member's approval, to change, interpret, modify, withdraw or add benefits or terminate this document. Any provision of this document which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations, (of the jurisdiction in which this document is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to this document unless it is made by an Amendment, which has been signed by one of Health Plan's officers. All of the following conditions apply:

(A) Amendments to this document are effective 31 days after Health Plan sends written notice to the Group.

(B) Riders are effective on the date Health Plan specifies.

(C) No agent has the authority to change this document or to waive any of its provisions.

(D) No one has authority to make any oral changes or amendments to this document.

12.8 Clerical Error

If a clerical error or other mistake occurs, that error will not deprive Member of benefits under this document, nor will it create a right to benefits. If the Group makes a clerical error (including, but not limited to, sending Health Plan inaccurate information regarding Member's enrollment for coverage or the termination of Member's coverage under the this document) Health Plan will not make retroactive adjustments beyond a 60-day time period.

12.9 Information and Records

At times, Health Plan may need additional information from Member. Member agrees to furnish Health Plan with all information and proofs that Health Plan may reasonably require regarding any matters pertaining to this document. If Member does not provide this information when Health Plan requests it, Health Plan may delay or deny payment of Member's benefits. By accepting benefits under this document, Member authorizes and directs any person or institution that has provided services to Member to furnish Health Plan with all information or copies of records relating to the services provided to Member. Health Plan has the right to request this information at any reasonable time. Health Plan agrees that such information and records will be considered confidential. Health Plan has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this document, for appropriate medical review or quality assessment, or as Health Plan is required to do by law or regulation. During and after the term of this document, Health Plan and our related entities may use and transfer the information gathered under this document in a de-identified format for commercial purposes, including research and analytic purposes. For complete listings of your medical records or billing statements Health Plan recommends that Member contact his or her health care provider. Providers may charge Member reasonable fees to cover their costs for providing records or completing requested forms. If Member requests forms or records from us, Health Plan also may charge Member reasonable fees to cover costs for completing the forms or providing the records. In some cases, Health Plan will designate other persons or entities to request records or information from or related to Member, and to release those records as necessary. Health Plan's designees have the same rights to this information as Health Plan has.

12.10 Preventive Health Information

Health Plan has preventive health information on its websites, **www.myoptumhealthphysicalhealthofca.com** and **www.myoptumhealth.com**. The information is presented to educate members on prevention of musculoskeletal injuries or conditions. The information is not intended to replace the advice received from your medical care provider. Any information taken from the website should be discussed with your medical provider to determine whether it is appropriate for your condition.

Service Area Counties

Approved service area counties are listed below. Please refer to CalPERS On-Line's Health Plan Search by Zip Code tool for the approved ZIP codes within each service area county.

- Alameda
- Contra Costa
- Fresno
- Kern
- Kings
- Los Angeles (partially covered county)
- Madera (partially covered county)
- Marin
- Merced
- Orange
- Placer (partially covered county)
- Riverside (partially covered county)
- Sacramento
- San Bernardino (partially covered county)
- San Diego
- San Francisco
- San Joaquin
- San Mateo
- Santa Clara
- Santa Cruz
- Solano
- Sonoma
- Stanislaus
- Ventura (partially covered county)
- Yolo

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

Customer Service:
1-877-359-3714
711 (TTY)
www.uhc.com/calpers

Effective 1/1/2016

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PCA741098-000

Rev. 8/15