FORM APPROVED COUNTY COUNSEL
BY: ANITA C. WILLIS DATE 6-10-15

Departmental Concurrence

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

321

FROM: Human Resources Department

SUBMITTAL DATE:
April 30, 2015

SUBJECT: Ratify the Medical and Hospital Group Subscriber Agreement (HMO) with UHC of California for the 2015 Calendar Year. [District- ALL] [Total Cost - $0] [SOURCE OF FUNDS - Employee and Retiree Health Premiums]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the Medical and Hospital Group Subscriber Agreement between UHC of California dba UnitedHealthcare of California and the County of Riverside for the period of January 1, 2015 through December 31, 2015 (Attachment A);
2. Authorize the Chairperson to sign four (4) copies of each Agreement; and
3. Retain one (1) copy of each agreement and return three (3) copies of each agreement to Human Resources for distribution.

BACKGROUND:

Summary

The Human Resources Department collaborated with Aon (benefits consultant) to conduct a formal RFP, as directed by the Board of Supervisors on April 22, 2014. The RFP was sent to various medical plan providers. UHC offered the most competitive plan design, premiums and innovative solutions.

Michael T. Stock
Asst. County Executive Officer/
Human Resources Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$	$	$	$	Consent ☐ Policy ☒
NET COUNTY COST	$	$	$	$	

SOURCE OF FUNDS: Employee and Retiree Health Premiums

Budget Adjustment: No

For Fiscal Year: 2014/15-15/16

C.E.O. RECOMMENDATION:

APPROVE
BY: Lani Sioson

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Ashley, seconded by Supervisor Benoit and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Tavaglione, Washington, Benoit and Ashley
Nays:	None
Absent:	None
Date:	June 30, 2015
xc:	H.R.

Kecia Harper-Ihem
Clerk of the Board
By: _____ Deputy

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: 07/15/14, 3.44 | **District: ALL** | **Agenda Number:** 3-31

BACKGROUND:

Summary

The selection of UHC as a replacement to Health Net provides County employees and retirees' greater network access and lower costs on national and local levels.

In addition to patient network access, UHC understands the County's need to have a strategic partner to assist County employees and retirees to achieve a healthier lifestyle and to aggressively manage cost.

UHC's proven innovative solutions include: 1) clinical effectiveness, using evidence–based medicine which costs less and consistently delivers better health results; 2) information and technology, providing access to electronic health records, mobile technology, and live nurse chats; and 3) diverse products, to ensure County employees and retirees receive a broad range of customer-focused products and programs.

The Board of Supervisors approved the offering of UnitedHealthcare HMO and PPO plans for active employees and retirees as a replacement to the Health Net HMO and PPO plans, on July 15, 2014, Item 3-44. The approved rates were below market trend, based on the County's current plan design. The 2015 UHC HMO average plan rates did not increase compared to the prior carrier's rates and the 2015 UHC PPO average plan rates decreased by 1%. The current average market trend premium increase for active employees is 8% for HMO plans and 8.6% for PPO plans.

The Group HMO plan (Attachment A) is offered to eligible County employees and early retirees.

Impact on Residents and Businesses

There is no direct impact to residents or private businesses in the County of Riverside.

SUPPLEMENTAL:

Additional Fiscal Information

The total annual cost for the Group HMO plan is $28,431,023. Currently, 2,467 active County employees and 78 early retirees are enrolled in the HMO plan. There is no direct cost to the County for the recommended action. UnitedHealthcare health insurance premiums are paid by employees and early retirees enrolled in the plan.

Contract History and Price Reasonableness

UHC is a Fortune 500 company and named World's Most Admired Company in the insurance and managed care sector, from 2011 through 2014. UHC provides health benefits and services to more than 85 million individuals worldwide.

This calendar year represents the first year that the County has contracted with UHC for medical benefits. As a result, Human Resources is in the process of finalizing contract negotiations with United Healthcare for the PPO and the Medicare Advantage retiree plans. The PPO and Medicare Advantage contracts will be submitted to the Board for approval immediately upon finalization of the contract provisions.

ATTACHMENTS:

A. **Medical and Hospital Group Subscriber Agreement (HMO), including Coversheet and Combined Evidence of Coverage and Disclosure Form**

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ATTACHMENT A

Medical and Hospital Group Subscriber Agreement
(HMO), including Coversheet and
Combined Evidence of Coverage and Disclosure Form

JUN 3 0 2015 3-31

UHC OF CALIFORNIA dba UNITEDHEALTHCARE OF CALIFORNIA

MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

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MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

This Medical and Hospital Group Subscriber Agreement (the "Agreement") is entered into between UHC of California dba United Healthcare of California, a California corporation, hereinafter called "UnitedHealthcare," and the County of Riverside, a political subdivision of the State of California, hereinafter called "Group."

RECITAL OF FACTS

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

AGREEMENT

NOW THEREFORE, in consideration of the mutual covenants and conditions contained in this Agreement, UnitedHealthcare and Group agree as follows:

1. DEFINITIONS

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

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

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

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

1.05 Dependent is any legal spouse, registered Domestic Partner or child (including a step-child, adopted child, child(ren) for whom the Subscriber, the Subscriber's spouse or Domestic Partner has assumed permanent guardianship or a child of a Domestic Partner) of a Subscriber who is enrolled hereunder, who meets all the

eligibility requirements set forth by Group in the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form attached to this Agreement and for whom applicable Health Plan Premiums are received by UnitedHealthcare.

1.05(a) Domestic Partner is a person who meets the eligibility requirements, as defined by the Group, and the following:

(i) Is eighteen (18) years of age or older. An exception is provided to Subscribers and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
   a. Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
   b. A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.

(ii) Is mentally competent to consent to contract;

(iii) Is unmarried or not a member of another domestic partnership;

(iv) Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the State of California; and

(v) Have registered as domestic partners by filing a Declaration of Domestic Partnership with the California Secretary of State.

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

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

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

1.07 Enrollment is the execution of the Group's Benefit Election form, or a non-standard Enrollment form such as an electronic enrollment approved by the Group, by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by Group and UnitedHealthcare, conditioned upon the execution of this Agreement by UnitedHealthcare, and either the execution of this Agreement by Group or the timely payment of applicable Health Plan Premiums by Group. Subject to specific protocols, UnitedHealthcare will accept Enrollment through an electronic submission from Group.

1.08 Group is the County of Riverside, a political subdivision of the State of California.

1.09 Group Contribution is the amount of the Health Plan Premium applicable

to each Subscriber which is paid solely by the Group or employer and which is not paid by the Subscriber either through payroll deduction or otherwise.

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

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

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

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

1.14 Open Enrollment Period is the annual period established by Group, during which all eligible and prospective Group Subscribers and their eligible Dependents may enroll in this Health Plan.

1.15 UnitedHealthcare Enrollment Packet is the packet of information supplied by UnitedHealthcare to prospective Subscribers which discloses plan policy and procedure and provides information about Plan benefits and exclusions. The UnitedHealthcare Enrollment Packet contains the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form.

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

2. ELIGIBILITY AND ENROLLMENT

2.01 Enrollment Procedure

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

2.01.02 Time of Enrollment. All applications for Enrollment shall be submitted by prospective Subscribers to the Group during Open Enrollment Periods, except that prospective Subscribers and their eligible Dependents who were not eligible during the previous Open Enrollment Period may apply for Enrollment within sixty (60) days after becoming eligible ("60 Day Period"). All applications received by Group within the 60 Day Period shall be submitted by Group to UnitedHealthcare within ninety (90) days from the date the prospective Subscriber or Dependent becomes eligible. All applications for Enrollment which are not received by Group within the 60 Day Period may be subject to rejection by Group. Prospective Subscribers and their eligible Dependents may reapply at the next Open Enrollment Period in the event an application was not received by Group within the 60 Day Period. Group shall provide notice to Members of the applicable Open Enrollment Periods.

2.01.03 Notice. Group shall provide a written notice to Eligible Employees at the commencement of the initial Open Enrollment Period or special enrollment. The written notice shall provide notice of the availability of coverage under Group sponsored medical plans and indicate that an Eligible Employee's failure to elect coverage, on his or her behalf or on behalf of his or her eligible Dependents during the initial Open Enrollment Period or special enrollment, permits Group to exclude medical coverage for a period of up to twelve (12) months until Group's next open enrollment period. Group shall require any Eligible Employee declining Group sponsored medical coverage on behalf of himself or herself or any eligible Dependent, to certify on the written notice that he or she has reviewed the notice and understands the consequences of declining Group sponsored medical coverage. Group agrees to submit completed notices to UnitedHealthcare, upon written request by UnitedHealthcare, for each Eligible Employee and/or his or her eligible Dependents who enrolled in the Health Plan and subsequently declined coverage at renewal of this Agreement.

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

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

2.03 UnitedHealthcare's Liability in the Event of Conversion from a Prior Carrier. In the event UnitedHealthcare replaces a prior carrier responsible for the payment of benefits or provision of services under a group contract within a period of sixty (60) days from the date of discontinuation of the prior contract or policy, UnitedHealthcare will immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuation, and who are eligible for enrollment under this Agreement, without regard to health status or hospital confinement.

Notwithstanding the foregoing, with respect to employees or dependents who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code or Section 10128.2 of the California Insurance Code under the prior contract or policy, UnitedHealthcare shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

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

3.02 Notices to UnitedHealthcare. Group shall forward via electronic file feed all completed or amended enrollments for each Member for receipt by UnitedHealthcare within ninety (90) days of the Member's initial eligibility. Group acknowledges that any Enrollment applications not received by UnitedHealthcare within such ninety (90) day period may be rejected by UnitedHealthcare. Group further agrees to transmit to UnitedHealthcare any Enrollment application amendments.

Group shall forward all notices of termination to UnitedHealthcare within ninety (90) days after Member loses eligibility or elects to terminate membership under this Agreement. Group agrees to pay any applicable Member Health Plan Premiums through the last day of the month in which notice of termination is received by UnitedHealthcare.

3.03 Notices to Subscriber. If Group or UnitedHealthcare terminates this Agreement pursuant to Section 7 below, Group shall promptly notify all Subscribers enrolled through Group of the termination of their coverage in this Health Plan. For mid-year termination, Group shall, upon written request, promptly provide UnitedHealthcare with one sample copy of the notice of termination provided to Subscriber. UnitedHealthcare understands and agrees that Group shall not be required to provide UnitedHealthcare with a copy of the notice of termination provided to each Subscriber. In the event that UnitedHealthcare terminates this Agreement for non-payment of Health Plan Premiums or rescinds this Agreement for fraud or an intentional misrepresentation of a material fact, Subscribers will receive notice of termination from Group. Group shall notify all Subscribers of alternate coverage options available through Group.

If, pursuant to Sections 3.07.01 and 3.07.02 below, UnitedHealthcare increases Health Plan Premiums payable by the Subscriber or increases Copayments or reduces covered services provided under this Agreement, Group shall promptly notify all Subscribers enrolled through Group of such increase or reduction during the enrollment period. In addition, Group shall promptly notify Subscribers enrolled through Group of any other changes in the terms or conditions of this Agreement affecting the Members' benefits or obligations under the Health Plan. Group, upon written request, shall promptly provide UnitedHealthcare with one sample copy of the notice of Health Plan Premium increase or Copayment increase or reduction in covered services provided to Subscriber. UnitedHealthcare understands and agrees that Group shall not be required to provide UnitedHealthcare with a copy of such notice provided to each Subscriber. UnitedHealthcare shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.03.

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

3.04 Mutual Indemnification. Group and UnitedHealthcare agrees to indemnify, defend and hold harmless the other party, and to accept all legal and financial responsibility for any liability (including reasonable attorney's fees) arising out of its own failure to perform its obligations as set forth in this Agreement.

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

3.06 Due Date. Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to UnitedHealthcare on or before the last day of the second month after the month for which the premium applies. For example, Health Plan Premiums for January are due on or before the last day of March. Failure to provide payment on or before the end of the grace period, as provided in Section 6.02, may result in termination of Group, as set forth in Section 7.02.01 below. UnitedHealthcare reserves the right to assess an administrative fee of five percent (5%) of the monthly premium prorated on a thirty (30)-day month for each day it is delinquent after the end of the grace period. This fee will be assessed solely at UnitedHealthcare's discretion. In the event that deposit of payments not made in a timely manner are received by UnitedHealthcare after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by UnitedHealthcare within twenty (20) business days of receipt if UnitedHealthcare, in its sole discretion, does not reinstate Group.

3.07 Modification of Rates and Benefits.

3.07.01 Modification of Health Plan Premium Rates. The Health Plan Premium rates set forth on the Cover Sheet may be modified by UnitedHealthcare at renewal of this Agreement, provided that UnitedHealthcare provides one hundred eighty (180) days prior written notice mailed postage prepaid to Group and Group approves of such modification. Any such modification of the Health Plan Premium rates that are approved by Group shall take effect at renewal of this Agreement.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon UnitedHealthcare a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by UnitedHealthcare's gross receipts or any portions of either, then UnitedHealthcare may request payment of the pro rata amount sufficient to cover such taxes and license fees, rounded to the nearest cent, by providing ninety (90) days written notice to Group. Group, in its sole discretion, may pay or decline to pay such amount. Group will respond to UnitedHealthcare's request for payment on or before the end of the 90 day notice period. If Group declines to pay such amount, Group will provide thirty (30) days written notice of termination to UnitedHealthcare.

3.07.02 Modification of Benefits or Terms. UnitedHealthcare shall provide the UnitedHealthcare Enrollment Packet to Group in electronic form and Group shall ensure receipt of the packet along with a notification of the right to receive a hard copy of the packet as set forth in Section 3.10 below. If Group does not wish to receive the UnitedHealthcare Enrollment Packet in electronic form, Group may so notify UnitedHealthcare in accordance with Section 8.10 of the Agreement, and thereafter UnitedHealthcare will deliver the UnitedHealthcare Enrollment Packet to Group in paper format. The terms and conditions for Groups who transmit the UnitedHealthcare Enrollment Packet to its employees electronically are set forth in Section 3.10 below.

The covered services set forth in the Combined Evidence of Coverage and Disclosure Form and the Schedule of Benefits, and the Schedule of Supplemental Benefits in the UnitedHealthcare Enrollment Packet may be modified by UnitedHealthcare if required by State of California and/or Federal mandates and upon sixty (60) days written notice mailed postage prepaid to Group or as soon as reasonably practicable. Any such modification shall take effect as required by the legal mandate. UnitedHealthcare's written notice to Group shall include the following: (1) modification to the covered services, (2) the date the modification shall take effect as required by legal mandate, and (3) the citation to the legal mandate.

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

provided in the Combined Evidence of Coverage and Disclosure Form section of this Agreement.

3.09 Continuation of Benefits

3.09.01 Notice Regarding Continuation Coverage. With the exception of Domestic Partners and their Dependents, upon the occurrence of a qualifying event, as defined by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended by the 1986 Tax Reform Act (P.L. 99-514) and the 1986 Omnibus Budget Reconciliation Act (P.L. 99-509) ("COBRA"), Group shall provide affected Members with written notice of available continuation coverage as required by and in accordance with COBRA and amendments thereto. UnitedHealthcare shall be solely responsible for collecting Health Plan Premiums from Members who elect to continue benefits under COBRA. United Healthcare shall invoice such Members and direct them to submit Health Plan Premiums to United Healthcare due under this Agreement. United Healthcare shall maintain accurate records regarding Health Plan Premiums for Members who elect to continue benefits, including qualifying events, terminating events, and other information necessary to administer this continuation of benefits.

3.10 Enrollment Packets

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

   1.1 Group agrees to post on Group's website and if requested by an employee distribute an unmodified, electronic copy of the Enrollment Packet. Group agrees to send the Enrollment Packets to all employees who request a packet;

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

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

3. Employees receiving the Enrollment Packet electronically will also receive an electronic notification along with the electronic Enrollment Packet that they may request a hard copy of the packet from Group. Group agrees that it will continue to provide Enrollment Packets in paper form to those employees who request a hard copy or do not have access to the electronic Enrollment Packet.

UnitedHealthcare shall provide Enrollment Packets in paper form to the Group for distribution to UnitedHealthcare enrollees as they may request.

4. Group agrees that it will make the Enrollment Packet available to employees prior to the Group's renewal or during the entire open enrollment period. UnitedHealthcare agrees to make the Enrollment Packets available to Group at least four (4) weeks before Group's Annual Enrollment period.

4. BENEFITS AND CONDITIONS FOR COVERAGE

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

5. PARTIES AFFECTED BY THIS AGREEMENT; RELATIONSHIPS BETWEEN PARTIES

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

5.02 Compliance with the Health Insurance Portability and Accountability Act of 1996. UnitedHealthcare agrees to furnish written certification of prior creditable coverage ("Certificates") to all eligible Members, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). UnitedHealthcare and Group acknowledge that UnitedHealthcare's agreement to issue Certificates to all eligible Members relieves Group of its obligation under HIPAA to furnish Certificates. Group acknowledges that UnitedHealthcare must rely completely on eligibility information and data (including, but not limited to, Member's name and current address) furnished by Group in issuing Certificates to Members. Group agrees to notify UnitedHealthcare of all terminations within ninety (90) days of the termination, and to provide UnitedHealthcare with eligibility information and data within ninety (90) days of its receipt or change. Group agrees to indemnify, defend and hold UnitedHealthcare harmless and accept all legal, financial and regulatory responsibility for any liability arising out of Group's own failure to perform its obligations set forth in this Section in connection with UnitedHealthcare's furnishing Certificates to eligible Members under HIPAA.

6. TERM OF AGREEMENT; GRACE PERIOD

6.01 Term. The term of this Agreement shall be one (1) year, commencing on

January 1, 2015 (the "Effective Date") through December 31, 2015, unless this Agreement is terminated as provided herein.

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

7. TERMINATION AND RESCISSION OF COVERAGE

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

7.02 Termination by UnitedHealthcare.

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

7.02.01.01 Reinstatement Following Non-Payment of Premium. Notwithstanding Section 7.02.01, receipt by UnitedHealthcare of all Health Plan Premium payments then due and owing on or before the succeeding Health Plan Premium payment due date will reinstate this Agreement as though it had never been terminated. However, UnitedHealthcare may, in its discretion, elect not to reinstate this Agreement in any of the following circumstances: (1) the notice of termination states that, if Health Plan Premium payment is not received within thirty (30) days of issuance of the notice of termination, a new application is required and identifies conditions under which a new agreement will be issued or this Agreement reinstated; (2) if payment of Health Plan

Premiums is received by UnitedHealthcare more than thirty (30) days after the issuance of notice of termination, and UnitedHealthcare refunds such payment within twenty (20) business days of receipt; or, (3) if payment of Health Plan Premiums is received more than thirty (30) days after issuance of the notice of termination, and UnitedHealthcare issues to Group, within twenty (20) business days of receipt of such Health Plan Premiums, a new Agreement accompanied by written notice stating clearly those respects in which the new Agreement differs from this Agreement in benefits, coverage or otherwise. In the event UnitedHealthcare receives untimely payments after Group has been terminated, the deposit or application of such funds by UnitedHealthcare does not constitute acceptance of such funds or reinstate Group, and such funds may be refunded by UnitedHealthcare at its sole discretion.

7.02.03 For Fraud or an Intentional Misrepresentation of a Material Fact. UnitedHealthcare may terminate this Agreement sixty (60) days after UnitedHealthcare sends written notice to Group if Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Agreement (including any omissions, misrepresentations, or inaccuracies in the application form) or to the provision of coverage under this Agreement. In this case, UnitedHealthcare has the right to rescind this Agreement back to either:

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

UnitedHealthcare will send a notice to the Group via certified mail at least 60 days prior to the effective date of the rescission explaining the reason for the rescission and notifying Group of its right to appeal pursuant to Section 7.04.

UnitedHealthcare shall not rescind this Agreement due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the Effective Date of this Agreement pursuant to Section 8.16.

7.02.04 For Ceasing to Meet Group Eligibility Criteria. UnitedHealthcare may terminate Group upon ninety (90) days written notice to Group if Group fails to meet any of the following Group eligibility requirements:

(a) Group fails to maintain active participation percentage of seventy-five percent (75%) of all Eligible Employees in a Group sponsored medical plan. Eligible Employees who waive due to other group coverage being in force will not be counted toward this requirement;

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

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

(i) All Subscribers must have a Primary Residence within California; or

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

7.02.05 For Discontinuance of Health Plan. If UnitedHealthcare determines that it shall cease offering the Health Plan described in this Agreement, UnitedHealthcare may terminate this Agreement upon ninety (90) days written notice to the Director of Managed Health Care, the Group and all Members covered under this Health Plan. UnitedHealthcare shall make available to the Group all other health plans offered to new group business. In offering the option of other health plans, UnitedHealthcare shall act uniformly without regard to the claims experience of the Group or any health-status related factor relating to Members, Eligible Employees or their eligible Dependents.

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

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

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

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

termination due to non-payment of Health Plan Premiums pursuant to section 7.02.01.

7.04.02 Reinstatement Following Determination of Improper Cancellation, Rescission or Non-Renewal of Coverage. In the event the California Department of Managed Health Care determines UnitedHealthcare improperly canceled, rescinded or non-renewed this Agreement or a Member's coverage under the Health Plan, UnitedHealthcare will reinstate this Agreement or the Member's coverage under the Health Plan as though it had never been terminated. UnitedHealthcare will reimburse the Member within 30 days of receipt of a completed claim for any expenses incurred for covered services, as set forth in the Combined Evidence of Coverage and Disclosure Form, the Schedule of Benefits, and the Schedule of Supplemental Benefits. This provision does not apply to termination due to non-payment of Health Plan Premiums pursuant to section 7.02.01.

8. MISCELLANEOUS PROVISIONS

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

8.02 Names, Logos and Service Marks. UnitedHealthcare and Group each reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. However, either party may use the other party's name, product names, symbols, logos, trademarks, or service marks with the prior written approval of the other party.

8.03 Assignment. This Agreement and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by

either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party.

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

8.05 Confidentiality. UnitedHealthcare agrees to maintain and preserve the confidentiality of any and all medical records of Members in accordance with all applicable state and federal laws. UnitedHealthcare shall not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received covered services, unless authorized to do so by the Member or the release is otherwise permitted by law.

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

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

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

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

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

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

If to Group: County of Riverside
Human Resources Benefits Division
P.O. Box 1569

Riverside, CA 92502-1569
Attn: Stacey M. Beale, Human Resources Division Manager

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given five (5) business days after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United State Postal Service or courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone or email confirmation of receipt of the transmission, provided a copy is also delivered via personal delivery or mail.

8.11 Acceptance of Agreement. While the parties are negotiating the terms of this Agreement, Group agrees to make payment to UnitedHealthcare of Health Plan Premiums on or before the due date as set forth in Section 3.06 for covered services provided by UnitedHealthcare to Members. Execution of this Agreement by the parties shall render all terms and provisions of this Agreement binding on UnitedHealthcare and Group as of the Effective Date.

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

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

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

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

8.16 Time Limit on Certain Defenses. Pursuant to Section 7.02.03 above,

UnitedHealthcare shall not rescind this Agreement, terminate coverage, or increase Health Plan Premiums due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the Effective Date of this Agreement.

8.17 Notices to Member. UnitedHealthcare shall provide to Member all notices required or permitted under this Agreement in writing and either delivered personally or by regular, registered, or certified mail, U.S. Postal Service Express Mail, or overnight courier, postage prepaid, to Member's last address known to UnitedHealthcare.

8.18 Governing Law/Venue. This Agreement shall be governed by and interpreted in accordance with the laws of the State of California, without regard to applicable conflict of law rules. All actions and proceedings arising from this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California. The applicable provisions of the Government Claims Act (California Government Code Section 900, et seq.) must be followed first for any disputes under this Agreement.

8.19 Certification of Authority to Execute this Agreement. UnitedHealthcare certifies that the individual signing herein on its behalf has the authority to execute this Agreement on behalf of UnitedHealthcare, and may legally bind UnitedHealthcare to the terms and conditions of this Agreement and any attachments.

9. ARBITRATION

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

the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, will also apply to the arbitration.

Group and UnitedHealthcare agree and understand that any and all disputes relating to this Agreement, except for claims subject to ERISA, shall be determined by submission to binding arbitration in accordance with the terms of this Agreement. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Group and UnitedHealthcare are giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

9.02 Disputes Between Member and UnitedHealthcare.

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

9.02.02 Binding Arbitration. The attached UnitedHealthcare Combined Evidence of Coverage and Disclosure Form includes a complete description of mandatory binding arbitration between UnitedHealthcare and Members.

(*Signatures on Following Page*)

Medical and Hospital Group Subscriber Agreement
Between the County of Riverside and
UHC of California dba UnitedHealthcare of California
Plan Year 2015

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as set forth below.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: JUN 3 0 2015

COUNTY OF RIVERSIDE

By: _____
Chairman, Board of Supervisors
MARION ASHLEY

Date: JUN 3 0 2015

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Brandon Cuevas

Title: CEO of California

Date: 4-2-15

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

GROUP NAME: County of Riverside

GROUP CODE: 356233 – Active, 356235 – COBRA, 356236 – Split Fam-OOA Deps
356240 – AB1401

GROUP COVERAGE EFFECTIVE DATE: January 1, 2015 through December 31, 2015

PLAN CODE: R80/R82/R83, AAM, IBD, BDX, 3I3

PLAN DESCRIPTION: SignatureValue (HMO) $15/$100A County of Riverside Plan with Acupuncture / ChiroCare-$15 / 20 Visits, Infertility Basic Diagnosis and Treatment, UnitedHealthcare of California Behavioral Health / SV&SVA SMI + BH Buy-Up Rider, and Custom Managed Formulary $10 Generic / $25 Brand / $50 Non-Formulary Outpatient Prescription Drugs

HEALTH PLAN PREMIUMS:		**AB1401**
Employee Only:	$ 617.83	$ 679.61
Employee + 1 Dependent:	$ 1,228.20	$ 1,351.02
Employee + Family:	$ 1,594.61	$ 1,754.07

BILLING CODE: 01*
* Charged entire month if eligible at least one day of the month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to UnitedHealthcare on or before the last day of the second month after the month for which the premium applies. For example, Health Plan Premiums for January are due on or before the last day of March.

ANNUAL COPAY MAXIMUM PER INDIVIDUAL: $ 1,500.00
ANNUAL COPAY MAXIMUM PER FAMILY: $ 3,000.00
CONTINUATION OF BENEFITS ELECTIONS: Yes

ELIGIBILITY:
Group Eligibility
Minimum hours required per week: 20

Dependent Member Eligibility
Dependent children are Eligible through age: 25

Start and End date of coverage: New and rehired employee's coverage starts on the first of the month following receipt of enrollment election form submitted to County of Riverside. Coverage ends on last day of termination month or end of the month following termination date if the next month full premium is collected.

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

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**
A - Schedule of Benefits, UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form
The following attachments below (D, I, L, and R) represent the Schedule of Supplemental Benefits:
D - Acupuncture / Chiropractic Services
I - Infertility Basic Diagnosis & Treatment
L - UnitedHealthcare of California Behavioral Health
R - Outpatient Prescription Drug Benefit

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

GROUP NAME: County of Riverside

GROUP CODE: 356237 – RS1M, 356238 – RSD1M, 356239 – RSD2M, 356234 – Early Retirees

GROUP COVERAGE EFFECTIVE DATE: January 1, 2015 through December 31, 2015

PLAN CODE: R80, AAM, IBD, BDX, 3I3

PLAN DESCRIPTION: SignatureValue (HMO) $15/$100A County of Riverside Plan with Acupuncture / ChiroCare-$15 / 20 Visits, Infertility Basic Diagnosis and Treatment, UnitedHealthcare of California Behavioral Health / SV&SVA SMI + BH Buy-Up Rider, and Custom Managed Formulary $10 Generic / $25 Brand / $50 Non-Formulary Outpatient Prescription Drugs

HEALTH PLAN PREMIUMS:

356237	Retiree & One Dep, One Medicare:	$ 953.41
356238	Retiree & Family, One Medicare:	$ 1,507.34
356239	Retiree & Family, Two Medicare:	$ 553.93
356234	Early Retiree Only,	$ 953.41
356234	Early Retiree & One Dep:	$ 1,895.33
356234	Early Retiree & Family:	$ 2,460.75

BILLING CODE: 01*
* Charged entire month if eligible at least one day of the month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to UnitedHealthcare on or before the last day of the second month after the month for which the premium applies. For example, Health Plan Premiums for January are due on or before the last day of March.

ANNUAL COPAY MAXIMUM PER INDIVIDUAL: $ 1,500.00
ANNUAL COPAY MAXIMUM PER FAMILY: $ 3,000.00
CONTINUATION OF BENEFITS ELECTIONS: Yes

ELIGIBILITY:
Group Eligibility
Minimum hours required per week: N/A
Dependent Member Eligibility
Dependent children are Eligible through age: 25

Start and End date of coverage: Coverage may start on the first of the month following retirement date. Coverage ends at the end of the month.

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

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**
* Early Retiree Addendum
A - Schedule of Benefits, UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form

The following attachments below (D, I, L, and R) represent the Schedule of Supplemental Benefits:
D - Acupuncture / Chiropractic Services
I - Infertility Basic Diagnosis & Treatment
L - UnitedHealthcare of California Behavioral Health
R - Outpatient Prescription Drug Benefit

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute the Cover Sheets to the Medical and Hospital Group Subscriber Agreement with an effective date of January 1, 2015.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: JUN 30 2015

COUNTY OF RIVERSIDE

By: _____
Chairman, Board of Supervisors
MARION ASHLEY

Date: JUN 30 2015

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Brandon Cuevas

Title: CEO of California

Date: 5/26/15

EARLY RETIREE ADDENDUM

TO THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

BETWEEN

UHC OF CALIFORNIA DBA UNITEDHEALTHCARE OF CALIFORNIA

AND

COUNTY OF RIVERSIDE

This Early Retiree Addendum ("Addendum") is attached to and made part of the UHC of California dba UnitedHealthcare of California Medical and Hospital Group Subscriber Agreement ("Agreement") between UHC of California dba United Healthcare of California, a California corporation, ("UnitedHealthcare") and the County of Riverside, a political subdivision of the State of California, ("Group") as of January 1, 2015 effective date.

WHEREAS, the parties desire to make certain modifications and/or additions to the Agreement regarding the Group's Eligible Early Retirees and Early Retiree Subscribers;

NOW THEREFORE, in consideration of the mutual promises, covenants and conditions hereinafter contained, the parties hereto mutually agree as follows:

A. DEFINED TERMS. Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning as set forth in the Agreement. With respect to Section 1 (Definition) of the Agreement, the parties agree to add the following:

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

1.18 Early Retiree Subscriber is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by UnitedHealthcare, and who meets the eligibility criteria as defined by the Group."

B. EARLY RETIREES. Except as otherwise set forth herein, all terms and conditions of the Agreement, including but not limited to the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form, applicable to Eligible Employees and Subscribers shall apply to Eligible Early Retirees and Early Retiree Subscribers respectively.

(1) The parties agree that the Cover Sheet, which refers to Group Code 356237 – RSIM, 356238 – RSDIM, 356239 – RSD2M, and 356234 – Early Retirees, shall apply to Eligible Early Retirees and Early Retiree Subscribers.

(2) The parties agree that the Cover Sheet, which refers to Group Code 356233 – Active, 356235 – COBRA, 356236 – Split Fam-OOA Deps, and 356240 – AB1401, applies to Eligible Employees and Subscribers and shall not apply to Eligible Early Retirees and Early Retiree Subscribers.

C. EFFECT OF ADDENDUM. This Addendum is made effective as of January 1, 2015 through December 31, 2015. The provisions of this Addendum shall prevail over any provisions in the Agreement that conflict or appear inconsistent with any provision in this Addendum. Except as otherwise modified by this Addendum, all other provisions of the Agreement shall remain in full force and effect.

(Signatures on Following Page)

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute this Early Retiree Addendum to the Medical and Hospital Group Subscriber Agreement with an effective date of January 1, 2015.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: JUN 3 0 2015

COUNTY OF RIVERSIDE

By: _____
Chairman, Board of Supervisors
MARION ASHLEY

Date: JUN 3 0 2015

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Brandon Cuevas

Title: CEO of California

Date: 5/26/15

COUNTY OF RIVERSIDE

UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Schedule of Benefits
15/100a

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
PCP Office Visits	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits[2] (Member required to obtain referral to specialist or nonphysician health care practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$15 Office Visit Copayment
Hospital Benefits (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	$100 Copayment per admit
Emergency Services (Copayment waived if admitted)	$100 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)	$35 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$100 Copayment per admit
Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	$100 Copayment per admit
Hospital Benefits[4] (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	$100 Copayment per admit
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$100 Copayment per admit
Maternity Care[8]	$100 Copayment per admit

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services (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.)** **(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment)**	$100 Copayment per admit
Newborn Care[4]	$100 Copayment per admit
Physician Care	Paid in full
Reconstructive Surgery	$100 Copayment per admit
Rehabilitation Care (Including physical, occupational and speech therapy)	$100 Copayment per admit
Skilled Nursing Facility Care (Up to 100 days per benefit period)	$100 Copayment per admit
Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $125 Copayment $200 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment
Ambulance	Paid in full
Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices[5] (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	$15 Copayment per item
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$15 Copayment
Dialysis (Physician office visit Copayment may apply)	Paid in full
Durable Medical Equipment[5]	Paid in full
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.)	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Family Planning (Non-Preventive Care)[9]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[9]	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner 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)	
1st trimester	$125 Copayment
2nd trimester (12-20 weeks)	$200 Copayment
– After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	
Hearing Aid - Standard ($5,000 benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years.)	Paid in full
Hearing Aid - Bone Anchored[7] 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.
Hearing Exam[2,8]	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit[2]	$15 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	$15 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Infertility Services	Not covered
Infusion Therapy[5] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	$150 Copayment
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)[5,9] (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. 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)	Paid in full
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply)	Paid in full
Maternity Care, Tests and Procedures[8]	
PCP Office Visit	Paid in full
Specialist/Nonphysician Health Care Practitioner Office Visit	Paid in full
Mental Health Services (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

Benefits Available on an Outpatient Basis (Continued)

Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment
Oral Surgery Services[5]	$100 Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	Paid in full
Physician Care PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment
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.	Paid in full
Prosthetics and Corrective Appliances[5]	Paid in full
Radiation Therapy[5] Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	 Paid in full Paid in full
Radiology Services[5] Standard (Additional Copayment for office visits may apply): Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	 Paid in full Paid in full
Vision Refractions PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment

Note: Benefits with Percentage Copayment amounts are based upon the UnitedHealthcare negotiated rate.

[1]The Annual Copayment Maximum includes Copayments for UnitedHealthcare benefits, including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision, Acupuncture, and Chiropractic benefit plans offered to groups.

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

[3]Clinical Trial services require preauthorization by UnitedHealthcare. If you participate 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, 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.

[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. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Replacement of external hearing aid components are covered under the Durable Medical Equipment benefit. 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.

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

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

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

UnitedHealthcare®

Mental Health Services, Substance Use Disorder Services and Severe Mental Illness Benefits

Offered by U.S. Behavioral Health Plan, California

Plan BDX

Schedule of Benefits

Pre-Authorization is required for certain Mental Health Services, Substance Use 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, 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, Residential and Day Treatment Medically Necessary Mental Health services provided at an Inpatient Treatment Center or a Day Treatment Center	Same as medical plan Inpatient Mental Health Services Copayment[1]
Outpatient Treatment When such Services are provided at the office of a Participating Practitioner or at an Outpatient Treatment Center.	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 Use Disorder Services

Inpatient Treatment For Medically Necessary treatment of Substance Use Disorders, Including Medical Detoxification, when provided at a Participating Facility	Paid in full
Outpatient Treatment	Paid in full
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, Residential and Day Treatment Unlimited days	Same as medical plan Inpatient Mental Health Services Copayment[1]
Outpatient Treatment 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.

P.O. Box 2839
San Francisco, CA 94126

Customer Service:
800-999-9585
711 (TTY)
www.liveandworkwell.com

COUNTY OF RIVERSIDE

UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Pharmacy Schedule of Benefits

Summary of Benefits	Generic Formulary	Brand-name Formulary	Non-Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	**$10**	**$25**	**$50**
Mail Service Pharmacy Copayment (three Prescription Units or up to a 90-day supply)	**$20**	**$50**	**$100**

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

What do I pay when I fill a prescription?

You will pay only a Copayment when filling a prescription at a UnitedHealthcare Participating Pharmacy. You will pay a Copayment every time a prescription is filled. Your Copayments are as shown in the grid above.

There are selected brand-name medications where you will pay a generic Copayment of just $10. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's Web site at **www.uhcwest.com**.

Preauthorization

Selected generic Formulary, brand-name Formulary and non-Formulary medications require a Member to go through a Preauthorization process using criteria based upon Food and Drug Administration (FDA)-approved indications or medical findings, and the current availability of the medication. UnitedHealthcare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard professional practice and are not otherwise excluded from coverage.

Because UnitedHealthcare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives, or non-Formulary preferred drugs have been tried. UnitedHealthcare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary. Participating Physicians may call or fax Preauthorization requests to UnitedHealthcare. Applicable Copayments will be charged for prescriptions that require Preauthorization if approved.

For a list of the selected medications that require UnitedHealthcare's Preauthorization, please contact UnitedHealthcare's Customer Service department.

Medication Covered by Your Benefit

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

- **Disposable all-in-one prefilled insulin pens**, insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary, in accordance with UnitedHealthcare's Preauthorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs unless they are on UnitedHealthcare's Selected Brands List. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department or may be found on UnitedHealthcare's Web site at **www.uhcwest.com**.
- **Miscellaneous Prescription Drug Coverage**: For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips,

lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to, EpiPen®, Ana-Kits® and Ana-Guard®). See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medications in Section Five under "Your Medical Benefits."

- **Oral Contraceptives:** Federal Legend oral contraceptives, prescription diaphragms and oral medications for emergency contraception.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only, according to state law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Fiveof your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered Drugs**: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered under your medical benefit.
- **Compounded Medication**: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Preauthorized as Medically Necessary by UnitedHealthcare.
- **Diagnostic Drugs**: Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products and food supplements, whether prescription or nonprescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine, are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form.*
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Enhancement medications** when prescribed for the following nonmedical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical® or Meridia®. This exclusion does not exclude coverage for drugs when Preauthorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including, but not limited to, Alzheimer's dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your Employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for additional information.
- **Injectable Medications**: Except as described under the section "Medications Covered by Your Benefit," injectable medications, including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products, are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical *Combined Evidence of Coverage and Disclosure Form.* Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Preauthorization requirements. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* under "Your Medical Benefits."
- **Inpatient Medications**: Medications administered to a Member while an inpatient in a Hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are

obtained from a Participating Pharmacy in accordance with all the terms and conditions of coverage set forth in this *Schedule of Benefits* and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy and pay the applicable Copayment on behalf of the Member.

- **Investigational or Experimental Drugs:** Medication prescribed for experimental or investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.
- **Medications dispensed by a non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved** by UnitedHealthcare are not covered unless Preauthorized by UnitedHealthcare as Medically Necessary.
- **Non-Covered Medical Condition**: Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-Covered Services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-Label Drug Use**. Off Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable Attachments. If a drug is prescribed for Off-Label Drug Use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) *The American Hospital Formulary Service Drug Information*, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen: (i) *The Elsevier Gold Standard's Clinical Pharmacology*; (ii) *The National Comprehensive Cancer Network Drug and Biologics Compendium*; (iii) *The Thompson Micromedex DRUGDEX*, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective. Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Medical Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form.*
- **Over-the-Counter Drugs:** Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription chemical and dosage equivalent available, even if ordered by a Physician, are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **Prior to Effective Date**: Drugs or medicines purchased and received prior to the Member's effective Date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or Durable Medical Equipment benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Form Section Five for additional information.
- **Sexual Dysfunction Medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmy or hyporgasmy, are not covered. An example of such medications includes Viagra.
- **Smoking cessation products,** including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray, are not covered. However, smoking cessation products are covered when the Member is enrolled in a smoking cessation program approved by UnitedHealthcare. For information on UnitedHealthcare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical

Benefits, in the section titled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our Web site at **www.uhcwest.com**.

- **Therapeutic devices or appliances,** including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as Durable Medical Equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating

  Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation**: Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about workers' compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Six under "Payment Responsibility."

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

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

CALIFORNIA

UnitedHealthcare®

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

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

Benefits

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

Diagnosis of Infertility

a. Complete medical history.

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

Treatment of Infertility

a. Insemination Procedures are limited to six procedures per lifetime, unless the Member conceives, in which case the benefit renews.

b. Clomid used during the covered periods of infertility is covered as part of this Supplemental Benefit and is not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage.

c. 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.

d. Injectable medications and syringes for the treatment of infertility are covered as part of this Supplemental Infertility Benefit and are not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage. Examples include:
   - Pergonal;
   - Profasi;
   - Metrodin;
   - Urofollitropin;

Coverage for other injectable drugs not listed above will be reviewed based on Medical Necessity for the specific Member, and Food and Drug Administration (FDA) recommendations, including off-label use for the drug requested.

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)).

Exclusions

- Services not authorized and directed by the Participating Medical Group or the Advantage Participating Medical Group (for Advantage participants).
- Medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, anorgasmy or hyporgasmy.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any supplies, medications, services and/or procedures used for an excluded benefit, e.g., , ZIFT or IVF.
- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.
- Experimental and/or Investigational diagnostic studies or procedures, as determined by UnitedHealthcare's Medical Director or Designee.
- Advanced infertility procedures, as well as In Vitro Fertilization (IVF), and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, and ZIFT.
- Infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when infertility exists; e.g., use of another relative's sperm.
- Artificial insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
   a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
   b. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;
2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the UnitedHealthcare Medical Director or designee determines that:
   a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
   b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
   c. The Member has received the lifetime benefit maximum of six artificial insemination procedures, cumulatively, under one or more UnitedHealthcare Health Plans, has occurred.
3. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes
4. Advanced Reproductive Therapy, as excluded under this Basic Infertility Services benefit are:
   a. In Vitro Fertilization (IVF). A highly sophisticated infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. If fertilization and cell division occur, the resulting embryo(s) are transferred to the uterine cavity where implantation and pregnancy may occur.
   b. Zygote Intrafallopian Transfer (ZIFT). An infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. The fertilized oocytes, or zygotes, are transferred to the fallopian tube before cell division occurs. The intent of this procedure is to have the zygote travel to the uterus via the fallopian tube.
5. Lifetime benefit maximum is individually cumulative for the Member over one or more UnitedHealthcare plans. Any Member that terminates from a UnitedHealthcare Health Plan with a lifetime benefit maximum, and subsequently re-enrolls in another

UnitedHealthcare Plan with a lifetime benefit maximum, will carry over any previous benefit utilization calculated by his or her previous UnitedHealthcare benefit coverage into the new UnitedHealthcare Benefit plan. In the event the Member has exhausted the lifetime benefit maximum on the previous UnitedHealthcare Health Plan, the Member is no longer eligible for any further benefits.

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

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

PCA9563-010
IBD

CALIFORNIA

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. In the case of acupuncture services, the services must be for a medically necessary diagnosis. Treatment is to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps and carpal tunnel syndrome.

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

Calculation of Annual Maximum Benefit Limits

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

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

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

Provider Eligibility

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

Types of Covered Services

Chiropractic Services:

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

2. Subsequent office visits, as set forth the treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.

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

4. A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

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

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

Acupuncture Services

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

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

3. A re-examination may be performed by the participating acupuncturist to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

Important OptumHealth Addresses:

Member Correspondence

OptumHealth of California, Inc.
Attn.: Member Correspondence Unit
P.O. Box 880009
San Diego, CA 92168-0009

Grievances and Complaints

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

Exclusions and Limitations

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

1. Any accommodation, service, supply or other item determined by health plan not to be medically necessary;

2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;

3. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-medically necessary purposes, and related expenses for reports, including report presentation and preparation;

4. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;

5. Experimental or investigative services unless required by an external, independent review panel as described in 16.5 of the EOC;

6. Services provided at a hospital or other facility outside of a participating provider's facility;

7. Holistic or homeopathic care including drugs and ecological or environmental medicine;

8. Services involving the use of herbs and herbal remedies;

9. Treatment for asthma or addiction (including but not limited to smoking cessation);

10. Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;

11. Transportation to and from a provider;

12. Drugs or medicines;

13. Intravenous injections or solutions;

14. Charges for services provided by a provider to his or her family member(s);

15. Charges for care or services provided before the effective date of the member's coverage under the Group Enrollment Agreement or after the termination of the member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;

16. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;

17. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;

18. Claims by providers who or which are not participating providers, except for claims for out-of-network emergency services or urgent services, or other services authorized by health plan;

19. Ambulance services;

20. Surgical services;

21. Services relating to member education (including occupational or educational therapy) for a problem not associated with a chiropractic disorder or acupuncture disorder, unless supplied by the provider at no additional charge to the member or to health plan;

22. Non-urgent services performed by a provider who is a relative of the member by birth or marriage, including spouse or domestic partner, brother, sister, parent or child; and

23. Emergency services. If a Member believes he or she requires emergency services, the member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Medical emergencies are covered separately by the member's medical plan.

CALIFORNIA

UnitedHealthcare of California

Combined Evidence of Coverage and Disclosure Form (HMO)
January 1, 2015

Welcome to UnitedHealthcare of California

Since 1978, we've been providing health care coverage in the state. 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'll 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 you 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 Copayments 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.uhcwest.com**. Together, these documents explain your coverage.

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

For certain Covered Services, a limit is placed on the total amount you pay for Copayments 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 Copayments 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 deductible or 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.

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at 1-800-624-8822 or 711 (TTY).

For certain Covered Services, a limit is placed on the total amount you pay for Copayments 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 Copayments 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 special attention to those sections that apply to them.

You may correspond with UnitedHealthcare at the following address:

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

1-800-624-8822

UnitedHealthcare's website is:

www.uhcwest.com

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- **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'll 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're a UnitedHealthcare Member, it's 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's written for **all** our Members receiving this plan, whether you're 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 these 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 don't 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's 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're 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'll find a list of our participating Primary Care Physicians in the *Provider Directory*. It's 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.)

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.uhcwest.com**.

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 don't 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 and the doctor is located within 30 miles of either the Member's Primary Residence or Primary Workplace.

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 Preauthorized 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's 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 60-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 1-800-624-8822 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've 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

1-800-624-8822

What is UnitedHealthcare's Case Management Program?

UnitedHealthcare has licensed registered nurses who, in collaboration with the Member, Member's designated family and the Member's 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've 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[SM] is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, 7 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're 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 1-800-624-8822.

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've 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've 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's 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's 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.uhcwest.com****.*

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. **Clinical Trials** – All Routine Patient Care Costs incurred during participation in an approved clinical trial for the treatment of:
   - Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
   - Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying approved clinical trial criteria stated below.
   - Surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as we determine, a clinical trial meets the qualifying approved clinical trial criteria stated below.

- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying approved clinical trial criteria stated below.

Clinical trials are covered for a Member whose Participating Treating Physician recommends that the clinical trial has a meaningful potential to benefit the Member.

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

For the purposes of this benefit, "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 qualifying 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:

- The Investigational Service, device or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses. *Certain promising interventions* refer to treatment that is likely safe but where limited and/or conflicting evidence exists regarding its effectiveness.
- 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.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Health care services provided by the research sponsor free of charge.

With respect to cancer or other life-threatening diseases or conditions, a qualifying approved clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the United States Department of Defense (DOD) or the Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of Covered Service and is not otherwise excluded under the Agreement.

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

All services must 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