FORM APPROVED COUNTY COUNSEL
BY: GREGORY P. PRIAMOS DATE 11/25/15

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

101

FROM: Human Resources Department

SUBMITTAL DATE:
November 23, 2015

SUBJECT: Ratify the Letter of Understanding (LOU) and Group Policy (PPO) 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 Letter of Understanding (LOU) for the Group Policy (PPO) between UHC 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

On July 15, 2014, Item 3-44, the Board of Supervisors approved Human Resources' recommendation to offer United Healthcare medical plans to active employees and retirees as a replacement to Health Net plans effective January 1, 2015.

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

Lani Sioson

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Benoit, seconded by Supervisor Jeffries 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: December 15, 2015
xc: H.R.

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Departmental Concurrence

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

Prev. Agn. Ref.: 07/15/14, 3.44 | **District:** ALL | **Agenda Number:** 3-24

BACKGROUND:

Summary (continued)

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

Due to negotiated contract changes in alignment with the County's benefit plan administration, UHC must submit a case specific filing with the California Department of Insurance (CDI) for the County's PPO group policy and certificates of coverage. The case-specific filing process is expected to take at least 12 months to be reviewed and approved by CDI. While the PPO group policy and certificates of coverage are pending regulatory review/approval, the County must implement the LOU with UHC to ensure contractual provisions agreed by both parties are legally sound to protect the County's best interest while conducting business with UHC.

The LOU for the Group PPO plan (Attachment A) is applicable to County employees and retirees who elect the UHC medical plans offered by the County.

Impact on Residents and Businesses

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

SUPPLEMENTAL:

Additional Fiscal Information

This year's total annual cost for the Group PPO plan is approximately $2 million for active employees and early retirees and a total of $148,000 for Medicare eligible retirees. Currently, there are 115 active employees, 16 early retirees, and 14 Medicare eligible retirees enrolled in the UHC PPO plan.

There is no direct cost to the County for the recommended action. UHC's medical premiums are paid by employees and retirees enrolled in the plan.

Contract History and Price Reasonableness

The 2015 UHC PPO average plan rates decreased by 1% for active employees, increased by 4% for early retirees, and increased by 1% for Medicare retirees as compared to the prior carrier's rates. For PPO plans, the current average market trend premium increase for active employees and early retirees is 7.6%.

UHC was the top ranking company in the insurance and managed care sector on Fortune's 2015 "World's Most Admired Companies" list. UHC provides health benefits and services to more than 85 million individuals worldwide.

ATTACHMENT:

A. **Letter of Understanding for the Group Policy (PPO), including Certificate of Coverage for Plans: PUZ, PVI, PR3 (Option 1), and PR3 (Option 2)**

LETTER OF UNDERSTANDING
BETWEEN
UNITEDHEALTHCARE INSURANCE COMPANY
AND
COUNTY OF RIVERSIDE

This Letter of Understanding is made by and between the UnitedHealthcare Insurance Company ("UHC"), a Connecticut corporation, and County of Riverside ("Enrolling Group"), a political subdivision of the State of California, and referred to collectively as the "Parties."

WHEREAS, UHC has prepared the Group Policy for the County of Riverside (Enrolling Group Number 902805) with the effective date of January 1, 2015 ("Policy"); and,

WHEREAS, the Parties have negotiated in good faith and agreed to the terms, conditions and provisions of the Policy and the accompanying Certificates of Coverage subject to regulatory review and/or modification and final approval by the California Department of Insurance;

NOW, THEREFORE, in consideration of the mutual promises, covenants and conditions contained herein, the Parties hereto agree as follows:

1. Pending regulatory approval of the Policy and Certificates of Coverage by the California Department of Insurance ("Department"), the Parties agree to comply with all terms, conditions and provisions of the Policy and Certificates of Coverage, which are attached hereto and incorporated herein by this reference:

Exhibit A	United Healthcare Insurance Company Group Policy for the County of Riverside
Exhibit B	UnitedHealthcare Non-Differential PPO, UnitedHealthcare Insurance Company Certificate of Coverage for Plan PUZ of County of Riverside
Exhibit C	UnitedHealthcare Select, UnitedHealthcare Insurance Company Certificate of Coverage for the Plan PVI of County of Riverside
Exhibit D	UnitedHealthcare Select Plus, UnitedHealthcare Insurance Company Certificate of Coverage for the Plan PR3 (Option 1) of County of Riverside
Exhibit E	UnitedHealthcare Select Plus, UnitedHealthcare Insurance Company Certificate of Coverage for the Plan PR3 (Option 2) of County of Riverside

2. UHC shall promptly, but no later than 30 days following the Parties' execution of this Letter of Understanding, make the appropriate filings with the Department for regulatory approval of the attached Policy and Certificates of Coverage (collectively "Filings"). UHC shall

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promptly, but no later than 30 days following UHC's receipt of the Department's determinations regarding such Filings, provide written notice of the Department's determinations to the Enrolling Group. UHC shall deliver such notice to the Enrolling Group in accordance with Section 9 of Exhibit 1 of the Policy.

3. Enrolling Group understands that the attached Policy and Certificates of Coverage have been materially modified from their filed and approved templates. UHC cannot expressly guarantee that the Department will approve any of the material modifications entered into in good faith between the parties. Final approval is as determined by the Department and of which both parties agree to accept.

4. To the extent that the Department's final approval is inconsistent in any respect with the parties' negotiated agreement of the following specific provisions, UHC agrees that it will not determine the Enrolling Group to be in breach of contract if Enrolling Group has complied in good faith with such provisions:

(a) Section 3.3 (Adjustments to the Policy Charge), which states: "The Enrolling Group must notify us in writing or by electronic submission within 90 days of the effective date of enrollments, terminations, or other changes."

(b) Section 3.4 (Payment of the Policy Charge), which states: "The Policy Charge is due in full on a monthly basis by check or electronic transfer and must be paid directly by Enrolling Group to us on or before the last day of the second month after the month for which the Policy Charge applies. For example, the Policy Charge for January is due on or before the last day of March." "A late payment charge will be assessed for any Policy Charge not received within the 31 day grace period following the due date."

(c) Section 6.18 (Notice of Network Provider Termination), which states: "We will provide written notice of Network provider termination to the Enrolling Group and to all affected Subscribers and their Enrolled Dependents, within 30 days, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Enrolling Group or Covered Persons."

(d) Provisions in Section 6 (Payment of Policy Charge) of Exhibit 1, which states: "The Policy Charge is due and payable to us on a monthly basis on or before the last day of the second month after the month for which the Policy Charge applies. For example, the Policy Charge for January is due on or before the last day of March. A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due."

(e) Section 4 (Effective Date for Eligible Persons) of Exhibit 2 Class 2, Exhibit 2 Class 3, and Exhibit 2 Class 4, which states: "For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of

coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group."

5. To the extent that the Department's final approval is inconsistent in any respect with the parties' negotiated agreement of the following specific provisions, UHC agrees that it will not determine the Enrolling Group to be in breach of contract if Enrolling Group has complied in good faith with such provisions:

(a) Initial Enrollment Period" Section, which states: "Coverage begins on the date identified in the Policy if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date the Eligible Person becomes eligible to enroll."

(b) "Open Enrollment Period" Section, which states: "Coverage begins on the date identified by the Enrolling Group if the Enrolling Group receives the benefit election form and any required Premium within 60 days of the date the Eligible Person becomes eligible to enroll."

(c) "New Eligible Persons" Section, which states: "Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date the new Eligible Person first becomes eligible."

(d) "Adding New Dependents" Section, which states: "Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 60 days of the event that makes the new Dependent eligible."

(e) "Special Enrollment Period" Section, which states: "When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the event unless otherwise noted above." "For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date coverage under the prior plan ended."

6. This Letter of Understanding is made effective as of January 1, 2015 and shall automatically terminate on the date the Policy terminates or on the date of Enrolling Group's receipt of UHC's written notice of the Department's final determination of UHC's Filings, whichever occurs first.

7. This Letter of Understanding, including all attachments hereto, constitutes the entire agreement of the parties with respect to its subject matter and supersedes all prior and

contemporaneous representations, proposals, discussions and communications, whether oral or in writing. Except as otherwise set forth in the Group Policy, this Letter of Understanding may be changed or modified only by a written amendment signed by both parties. This Letter of Understanding shall be governed by the laws of the State of California with venue located in the County of Riverside, State of California.

8. UHC certifies that the individual signing below has the authority to execute this Letter of Understanding on behalf of UHC, and may legally bind UHC to the terms and conditions of this Letter of Understanding.

(*Signatures on Following Page*)

IN WITNESS WHEREOF, the parties hereto have executed this Letter of Understanding with an Effective Date of January 1, 2015.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: DEC 15 2015

COUNTY OF RIVERSIDE

By: _____
Chairman, Board of Supervisors

Date: DEC 15 2015 MARION ASHLEY

Approved as to Form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel

UNITEDHEALTHCARE INSURANCE COMPANY,
a Connecticut corporation

By: _____

Printed Name: Brandon Cuevas

Title: CEO of CA

Date: 11-2-15

EXHIBIT A

United Healthcare Insurance Company Group Policy for the County of Riverside

UnitedHealthcare Insurance Company

Group Policy

For

County of Riverside

Enrolling Group Number: 902805

Policy Effective Date: January 1, 2015

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-4357

TDD 800-482-4833

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage.*

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

We pay Benefits for Emergency Health Services that are required to stabilize or initiate treatment in an Emergency as described in the *Certificate of Coverage* and *Schedule of Benefits* to Covered Persons who receive such services outside of the Service Area.

Covered Health Services may be modified by us if required by any change in applicable law or regulation and upon sixty (60) days written notice to Enrolling Group or as soon as reasonably practicable. Such modification shall take effect as required by legal mandate. Our written notice to Enrolling Group shall include the following information: (1) modification to the Covered Health Services, (2) the date the modification shall take effect as required by legal mandate, and (3) the citation to the legal mandate.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change.*

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy subject to the approval of the Enrolling Group.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 90 days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing or by electronic submission within 90 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

We may modify the Premium at renewal of this Policy provided that Enrolling Group receives 180 days prior written notice and approves of such modification. Premium modification shall take effect at renewal of this Policy.

Notwithstanding the above, if premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges may be added to the Premium provided that Enrolling Group receives at least 90 days prior written notice and approves the increase in Premium. If Enrolling Group declines the increase in Premium, either party may terminate the Policy after at least 60 days prior written notice to the other party.

3.4 Payment of the Policy Charge

The Policy Charge is due in full on a monthly basis by check or electronic transfer and must be paid directly by Enrolling Group to us on or before the last day of the second month after the month for which the Policy Charge applies. For example, the Policy Charge for January is due on or before the last day of March.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within the 31 day grace period following the due date. Such late payment charge is five percent (5%) of the monthly Policy Charge prorated on a thirty (30)-day month for each day the payment is delinquent after the end of the grace period. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

3.5 Grace Period

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons and their Eligible Dependents may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Eligible Dependents is stated in Exhibit 2.

4.5 Waiver Form

The Enrolling Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Enrolling Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

C. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation or contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 60 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act or practice that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date of the act or practice, if later.

We will send a notice to the Enrolling Group via certified mail at least 60 days prior to the effective date of the rescission explaining the reason for the rescission and notifying Enrolling Group of its right to appeal as described in Article 5.3. We will not rescind this Policy due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Policy.

E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Except in the case of fraud or intentional misrepresentation of a material fact, we will refund the pro rata portion of any and all Policy Charges which have been prepaid by the Enrolling Group to reflect any reduced period of coverage at the time of termination of this Policy. The refund will be reduced by any amount paid for any claims incurred during the period this Policy was in force preceding the termination. Mid-month proration based on the eligibility rules established by the Enrolling Group will be used to refund Policy Charges. Exhibit 1 describes the way in which the Policy Charge is calculated.

5.3 Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

Enrolling Group may request a review by the California Insurance Commissioner if Enrolling Group believes this Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TDD 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Subscriber whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

6.2 Dispute Resolution and Binding Arbitration Requirement

This Policy requires that disputes be resolved in binding arbitration. The parties are waiving their right to sue in court to resolve a dispute and their right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, , the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in Riverside County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by federal and/or state law.

6.3 Time Limit on Certain Defenses

After two years from the date of issue of this Policy no misstatements made by the Subscriber in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such two-year period.

No claims for loss incurred or disability (as defined in this Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

6.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Except for changes to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and approved by Enrolling Group, except as provided in Article 2 of this Policy. Changes to Exhibit 2 may be stated in a Notice of Change to Exhibit 2 if approved by both parties. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

During and after the term of this Policy, we and our related entities may use and transfer de-identified information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.8 Governing Law/Venue

This Policy 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 Policy 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 Policy.

6.8 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive

coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 90 days of coverage prior to the date we received notification of the clerical error.

6.10 Workers' Compensation Not Affected

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

6.9 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of State of California or federal statutes or regulations is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.10 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, the Enrolling Group is responsible for giving notice to affected Subscribers and their Enrolled Dependents on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.11 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

Federal Continuation Coverage

We will provide administrative duties with respect to the Enrolling Group's compliance with federal law. The Enrolling Group will provide notification of COBRA continuation rights and we will provide services for billing and collection of Premium.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

We will provide all administrative duties required by Cal-COBRA, including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

6.12 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.13 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, each covered Subscriber may have access to his or her *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.14 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected. If we amend our security procedures that affect the Enrolling Group, we will provide Enrolling Group a 90 day prior written notice which shall include a copy of the amended security procedures.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the

Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

6.15 Important Notice - Disputes

Should a dispute concerning your coverage arise, contact us first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the **California Department of Insurance** at:

- **1-800-927-HELP (1-800-927-4357)** in the State of California.
- **213-897-8921** outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

6.16 Notice of Network Provider Termination

We will provide written notice of Network provider termination to the Enrolling Group and to all affected Subscribers and their Enrolled Dependents, within 30 days, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Enrolling Group or Covered Persons.

6.17 Liability for Continued Treatment by Terminated Network Provider

If, upon termination of a Network provider's contract as described in Article 6.19, a Covered Person is under the care of a terminated Network provider for one of the medical conditions described in the *Continuity of Care* provision in the *Schedule of Benefits*, we will be liable for continuation of Covered Health Services rendered by the provider until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such Covered Health Services are made by another Network provider. Copayments, deductibles, or other cost sharing components will be the same as the Covered Person would have paid for a Network provider currently contracting with us.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity. However, care will be transitioned to a licensed provider who is not subject to medical disciplinary cause or reason, fraud or other criminal activity.

Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company, a Connecticut corporation, and County of Riverside, a political subdivision of the State of California, the Enrolling Group.

2. **Effective Date of this Policy**. The effective date of this Policy is 12:01 a.m. on January 1, 2015 in the time zone of the Enrolling Group's location.

3. **Place of Issuance**. We are delivering this Policy in the State of California. This Policy is governed by the laws of the State of California.

4. **Premiums**. The *Schedule of Premium Rates* specified in each Exhibit 2 may be modified pursuant to Sections 3.1 and 3.3 of this Policy.

5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.

6. **Payment of the Policy Charge**. The Policy Charge is due and payable to us on a monthly basis on or before the last day of the second month after the month for which the Policy Charge applies. For example, the Policy Charge for January is due on or before the last day of March. A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. 7. **Minimum Participation Requirement**. The minimum participation requirement for the Enrolling Group is 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled in Enrolling Group's sponsored medical plans.

8. **Minimum Contribution Requirement**. The Minimum Contribution Requirement does not apply.

9. **Notice**. Any notice sent to us under this Policy must be addressed to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Enrolling Group under this Policy must be addressed to:

   County of Riverside, Human Resources Benefits Division

   P.O. Box 1569

   Riverside, California 92502-1569

   Attn: Stacey M. Beale, Human Resources Division Manager

   Notice sent to us or Enrolling Group by registered or certified mail, return receipt requested, U.S. Postal Service Express Mail, or overnight carrier is deemed given on the date of delivery. If sent by regular mail, the notice is deemed given five (5) business days after its deposit in the United States mail, postage prepaid.

10. 902805: Enrolling Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plan PVI.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5.. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
EPO COB (Medicare A&B) + Dependents (> 65) Retiree Only	$579.96
EPO COB (Medicare A&B) + Dependents (> 65) Retiree plus One Dependent	$1,159.92
EPO COB (Medicare A&B) + Dependents (> 65) Retiree plus Family	$1,563.78
EPO COB + HMO (For EPO COB) Retiree plus Spouse (1 Medicare)	$1,533.37
EPO COB + HMO (For EPO COB) Retiree plus Family (1 Medicare)	$2,087.30
EPO COB + HMO (For EPO COB) Retiree plus Family (2 Medicare)	$1,713.85

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plus Plan PR3 (Option 1).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
PPO (Non-Blythe) - Active/COBRA Employee Only	$955.73
PPO (Non-Blythe) - Active/COBRA Employee plus One Dependent	$1,899.95
PPO (Non-Blythe) - Active/COBRA Employee plus Family	$2,466.74
PPO (Non-Blythe) - AB1401 Employee Only	$1,051.30
PPO (Non-Blythe) - AB1401 Employee plus One Dependent	$2,089.95
PPO (Non-Blythe) - AB1401 Employee plus Family	$2,713.41
PPO (Non-Blythe) - ERET Employee Only	$1,345.67
PPO (Non-Blythe) - ERET Employee plus One Dependent	$2,583.93

PPO (Non-Blythe) - ERET Employee plus Family	$3,473.18
PPO - Out of Area Dependents (Students) with HMO Subscriber	$0.00

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plus Plan PR3 (Option 2).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
PPO COB (Blythe and Non-Blythe) (Medicare A&B) Retiree Only (> 65)	$814.39
PPO COB (Blythe and Non-Blythe) (Medicare A&B) Retiree plus One Dependent (> 65)	$1,628.78
PPO COB (Blythe and Non-Blythe) (Medicare A&B) Retiree plus Family (> 65)	$2,195.88
PPO (Blythe and Non-Blythe) (For PPO COB) Retiree plus One Dependent (1 Medicare)	$2,160.06
PPO (Blythe and Non-Blythe) (For PPO COB) Retiree plus Family (1 Medicare)	$2,941.90

PPO (Blythe and Non-Blythe) (For PPO COB) Retiree plus Family (2 Medicare)	$2,410.62

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 4

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Non-Differential PPO Plan PUZ.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
Non-Diff PPO COB (Medicare A&B)	$871.34
Non-Diff PPO COB (Medicare A&B) Retiree plus One Dependent (>65)	$1,742.68
Non-Diff PPO COB (Medicare A&B) Retiree plus Family (>65)	$2,349.44
Non-Diff PPO COB (Medicare A&B) Retiree plus One Dependent (1 Medicare)	$2,311.11
Non-Diff PPO COB (Medicare A&B) Retiree plus Family (1 Medicare)	$3,147.63
Non-Diff PPO COB (Medicare A&B) Retiree plus Family (2 Medicare)	$2,579.20

   Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 3 - Miscellaneous Provisions

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights and obligations of the Association.

COVERAGE

- **Persons Covered**

  Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

  The basic coverage protections provided by the Association are as follows:

  - **Life Insurance, Annuities and Structured Settlement Annuities**

    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - Life Insurance

      80% of death benefits but not to exceed $300,000

      80% of cash surrender or withdrawal values but not to exceed $100,000

    - Annuities and Structured Settlement Annuities

      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

    The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**

    The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance	California Department of Insurance
Guarantee Association	Consumer Communications Bureau
P.O. Box 16860	300 South Spring Street
Beverly Hills, CA 90209-3319	Los Angeles, CA 90013
(323) 782-0182	(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Summary of Benefits and Coverage Policy Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to address requirements for delivery of the *Summary of Benefits and Coverage (SBC)* as required under the *Affordable Care Act* and associated regulations *(ACA)*.

The following provision is added to the Policy under *Article 6: General Provisions*:

Summary of Benefits and Coverage

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

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

EXHIBIT B

UnitedHealthcare Non-Differential PPO, UnitedHealthcare Insurance Company Certificate of Coverage for Plan PUZ of County of Riverside

UnitedHealthcare Non-Differential PPO

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan PUZ

of

County of Riverside

Enrolling Group Number: 902805

Effective Date: January 1, 2015

Offered and Underwritten by

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

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Amendments, Riders and Notices (As Applicable)

UnitedHealthcare Non-Differential PPO

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a UnitedHealthcare Policy.

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air and ground.
- Breast cancer services.
- Clinical trials.
- Congenital heart disease surgery.
- Dental services - accidental.
- Dental anesthesia services.
- Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Formulas/specialized foods.
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Lab, X-ray and diagnostics - sleep studies.
- Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.
- Mastectomy services.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Behavioral Health Treatment.
- Obesity surgery.
- Pain management.
- Prosthetic devices over $1,000 in cost per device.
- Prosthetic devices incident to a laryngectomy.
- Reconstructive procedures.
- Rehabilitation services and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment

programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Surgery - only for the following outpatient surgeries: pain management procedures, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Temporomandibular joint services.
- Therapeutics - all outpatient therapeutics.
- Transplants.

For all other services, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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

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

Care Management

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

Special Note Regarding Medicare

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health	No Annual Deductible.

Payment Term And Description	Amounts
Services per year before you are eligible to receive Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Out-of-Pocket Maximum	
The maximum you pay per year for Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*. Coinsurance for Covered Health Services will apply to the Out-of-Pocket Maximum. Copayments for most Covered Health Services do not apply to the Out-of-Pocket Maximum, and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached. Please refer to each Covered Health Service category in the *Schedule of Benefits* table below to determine whether Copayments apply towards the Out-of-Pocket Maximum. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,350 per Covered Person, not to exceed $12,700 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of*	

Payment Term And Description	Amounts
Benefits table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Acupuncture Services			
Limited to 15 treatments per year.	100%	No	No
2. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	No	No
	Air Ambulance: 100%	No	No
Non-Emergency Ambulance Ground or air ambulance, as determined to be appropriate.	*Ground Ambulance:* 100%	No	No
	Air Ambulance: 100%	No	No
3. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
4. Congenital Heart Disease Surgeries			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
5. Dental Services - Accident Only			
Prior Authorization Requirement You must obtain prior authorization five business days or as soon as reasonably possible before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No
6. Diabetes Services			
Prior Authorization Requirement You must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
7. Diabetes Treatment			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.			
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician. Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
impaired with proper dosing of insulin.			
8. Durable Medical Equipment			
Prior Authorization Requirement You must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to orthotic appliances. This limit does not apply to wound vacuums.	100%	No	No
9. Emergency Health Services - Outpatient			
	100%	No	No
10. Hearing Aids			
Limited to $2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	100%	No	No
11. Home Health Care			
Prior Authorization Requirement You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	No	No
12. Hospice Care			
Prior Authorization Requirement You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required,			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	100%	No	No
13. Hospital - Inpatient Stay			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	100%	No	No
14. Lab, X-Ray and Diagnostics - Outpatient			
Prior Authorization Requirement For sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Lab Testing - Outpatient	100%	No	No
X-Ray and Other Diagnostic Testing - Outpatient	100%	No	No
15. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Prior Authorization Requirement You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No
16. Mental Health Services			
Prior Authorization Requirement For a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Behavioral Health Treatment. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Inpatient 100% *Outpatient* 100%	 No No	 No No
17. Obesity Surgery			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if obesity surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
18. Ostomy Supplies			
	100%	No	No
19. Pharmaceutical Products - Outpatient			
	100%	No	No
20. Physician Fees for Surgical and Medical Services			
	100%	No	No
21. Physician's Office Services - Sickness and Injury			
Prior Authorization Requirement You must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
22. Pregnancy - Maternity Services			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. **It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
23. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
24. Prosthetic Devices			
Prior Authorization Requirement You must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to % of Eligible Expenses.			
	100%	No	No
25. Reconstructive Procedures			
Prior Authorization Requirement You must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of*		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Benefits.		
26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Prior Authorization Requirement You must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 24 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	100%	No	No
27. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	No	No
28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Limited to 60 days per year.	100%	No	No
29. Substance Use Disorder Services			
Prior Authorization Requirement For a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Inpatient 100% *Outpatient* 100%	 No No	 No No
30. Surgery - Outpatient			
Prior Authorization Requirement For pain management procedures, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No
31. Temporomandibular Joint(TMJ) Services			
Prior Authorization Requirement You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.			
Covered Health Services are payable in the same manner as surgery for other medical conditions.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of*		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Benefits.		
32. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement You must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No
33. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
34. Urgent Care Center Services			
	100%	No	No
35. Vision Examinations			
Limited to 1 exam every 2 years.	100%	No	No
Additional Benefits Required By California Law			
36. Breast Cancer Services			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
37. Dental Anesthesia Services			
Prior Authorization Requirement You must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
Services are limited to Covered Persons who are one of the following: • A child under seven years of age. • A person who is developmentally disabled, regardless of age. • A person whose health is compromised and for whom general anesthesia is required, regardless of age.	100%	No	No
38. Mastectomy Services			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
39. Orthotic Benefit			
	100%	No	No
40. Osteoporosis Services			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
41. Phenylketonuria (PKU) Treatment			
Prior Authorization Requirement			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
You must obtain prior authorization before obtaining formulas or special food products for the management and treatment of Phenylketonuria (PKU). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	100%	No	No
42. Prosthetic Devices - Laryngectomy			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
43. Specialized Footwear			
	100%	No	No
44. Telehealth Services			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Eligible Expenses

Eligible Expenses are the amounts we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined in accordance with our reimbursement policy guidelines, as described in the *Certificate.*

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:

- For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

  If no fee information is available for a Covered Health Service, the Eligible Expense is based on 50% of the provider's billed charge, except that certain Eligible Expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge.

- For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

  When a rate is not published by *CMS* for the service we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

Provider Network

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

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

A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

Continuity of Care

If you are undergoing a course of treatment with a Network provider for one of the medical conditions below, and the Network provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the provider's agreement, for continuation of Covered Health Services rendered by the terminated provider for the time periods shown below. Copayments, deductibles or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

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

- **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a Sickness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Health Services will be provided for the duration of the acute condition.

- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, Sickness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Health

Services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Network provider, as determined by us in consultation with the Covered Person and the terminated Network provider and consistent with good professional practice. Completion of Covered Health Services under this provision will not exceed 12 months from termination date of the provider's agreement.

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

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

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

DIRECTORY OF NETWORK PROVIDERS

The current directory of Network providers is available online at www.myuhc.com.

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

You may contact us or the California Department of Insurance if you have a complaint regarding your ability to access needed health care in a timely manner as described in *IMPORTANT NOTICE - Network Provider Accessibility Complaints* in the *Certificate of Coverage* under *Section 6: Questions, Complaints and Appeals.*

Second Medical Opinion

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

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

- When you question the reasonableness or necessity of recommended surgical procedures;

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

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

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

Please Note: The fact that an appropriately qualified Physician gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is medically necessary or a Covered Health Service. If the recommended action is not medically necessary or is not a Covered Health Service, you will also remain responsible for paying any appropriate fees to the Physician who performs that recommended action.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage* (*Certificate*) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

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

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of California. The Policy, as a governmental plan, is exempt from ERISA. The laws of the State of California are the laws that govern the Policy.

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

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

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

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. You are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

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

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

Our administrative function regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received is based on this contract and is subject to the other terms, limitations and exclusions set out in this *Certificate* and *Schedule of Benefits*. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will do the following:

- Pay Benefits according to this Policy and subject to the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

Other persons or entities may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

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

Certificate of Coverage Table of Contents

Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

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

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

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

1. Acupuncture Services

Acupuncture services for the following conditions:

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

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as determined to be appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

3. Clinical Trials

Benefits include Covered Health Services for a Covered Person diagnosed with cancer and accepted into phase I, phase II, phase III, or phase IV clinical trial for cancer. Covered Health Services include all routine patient care costs related to the clinical trial, if the Covered Person's Physician recommends participation in the clinical trial based on his/her determination that such participation will have a meaningful potential to benefit the Covered Person, and if the clinical trial has a therapeutic intent.

An approved cancer clinical trial shall either: (1) involve a drug that is exempt under federal regulations from a new drug application or (2) be approved by one of the following:

- One of the *U.S. National Institutes of Health*.
- The *Federal Food and Drug Administration (FDA)* in the form of an investigational new drug application.
- The *United States Department of Defense (DOD).*
- The *United States Department of Veterans Affairs*.

For the purpose of this Benefit, "routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Policy if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

- 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.
- Heath care services needed for the reasonable and necessary care arising from the provisions of the investigational drug, item, device, or service, including the diagnosis of treatment of the complications.

For the purpose of this Benefit, "routine patient care costs" does not include the cost associated with the provision of any of the following:

- Drugs or devices that have not been approved by the *Federal Food and Drug Administration (FDA)* and that are associated with the clinical trial.

- Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that a Covered Person 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 that are not used in the clinical management of the Covered Person.
- Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the Policy.
- Health care services customarily provided by the research sponsors free of charge for any Covered Person in the clinical trial.

Benefits are available when the Covered Health Services are provided by either Network or non-Network providers. However, if the non-Network provider does not agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip and knees.
- Other diseases or disorders for which a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any 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).*
  - *Department of Defense (DOD).*
  - *Veterans Administration (VA).*
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

4. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

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

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

6. Diabetes Services

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

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

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

7. Diabetes Treatment

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

Benefits for diabetes prescription items (limited to insulin, medication for the treatment of diabetes, and glucagon) are described in the *Outpatient Prescription Drug Rider*.

8. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Treatment*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

9. Emergency Health Services - Outpatient

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

10. Hearing Aids

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

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

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

11. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

12. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

13. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)

14. Lab, X-Ray and Diagnostics - Outpatient

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

- Lab and radiology/X-ray.
- Mammography. Benefits are provided whether mammography testing is ordered or referred by a Physician, a nurse practitioner or a certified nurse midwife.

Benefits under this section include:

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

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.*

15. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

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

Benefits under this section include:

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

16. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.
- Prescription drugs, if the Policy includes an Outpatient Prescription Drug Rider.

Benefits under this section include the diagnosis and treatment of Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child under the same terms and conditions that apply to medical conditions as required by California insurance law. This includes, but is not limited to, Copayments and deductibles.

Benefits include Behavioral Health Treatment for pervasive developmental disorder or autism under the same terms and conditions that apply to medical conditions. Benefits for Behavioral Health Treatment shall not exceed the essential health benefits required under federal statutes and regulations.

Covered Health Services provided for Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child must meet the definitions of Severe Mental Illness or Serious Emotional Disturbances as defined in this *Certificate* in *Section 9: Defined Terms*.

The Mental Health/Substance Use Disorder Designee performs utilization review to determine whether the requested service is a Covered Health Service under the Policy for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

17. Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician.

18. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

19. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

20. Physician Fees for Surgical and Medical Services

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

21. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

22. Pregnancy - Maternity Services

Benefits for Pregnancy include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care.

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

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

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

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

When the mother and child are discharged early, coverage is provided for at least one post discharge follow-up visit within 48 hours of discharge, when prescribed by the treating Physician. A post discharge visit must be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit includes, at a minimum, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating Physician, in consultation with the mother, will determine whether the post discharge visit occurs at home, a birth facility, or the treating Physician's office. Prenatal diagnosis and counseling for genetic disorders are covered.

23. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including cancer screening tests.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including *FDA* approved AIDS vaccine if recommended by the *United States Public Health Services*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*, including screening for blood lead levels, Phenylketonuria (PKU) testing, periodic health evaluations, and laboratory services in connection with periodic health evaluations.

  Benefits for preventive care for children will be consistent with both of the following:

  - The *Recommendations for Preventive Pediatric Health Care*, as adopted by the *American Academy of Pediatrics*.
  - The most current version of the *Recommended Childhood Immunization Schedule/United States*, jointly adopted by the *American Academy of Pediatrics*, the *Advisory Committee on Immunization Practices*, and the *American Academy of Family Physicians*, unless determined otherwise by the *State Department of Health Services*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration,* including breast cancer screening, annual cervical cancer screening, osteoporosis screening, and screening mammography.

  Benefits defined under this requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits for a breast pump are provided taking into account the following determinations:

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

  Benefits for screening mammography include at least the following, upon order or referral of a Physician, a nurse practitioner, or a certified midwife:

  - A baseline mammogram for women age 35 to 39, inclusive.
  - A mammogram for woman age 40 to 49, inclusive, every two years or more frequently based on the women's Physician's recommendation.
  - A mammogram every year for woman age 50 and over.

- With respect to men, additional screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.

24. Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

25. Reconstructive Procedures

Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Cosmetic Procedures are excluded from coverage. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, including lymphedema, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services, limited to:

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

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

27. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

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

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

29. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee performs utilization review to determine whether the requested service is a Covered Health Service under the Policy for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

30. Surgery - Outpatient

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

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

Benefits under this section include:

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

31. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

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

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

32. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

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

33. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

34. Urgent Care Center Services

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

35. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By California Law

36. Breast Cancer Services

Benefits include diagnosis of, and treatment for, breast cancer. (Benefits for breast cancer screening are described under *Preventive Care Services*.)

37. Dental Anesthesia Services

Services including general anesthesia and associated Hospital or Alternate Facility charges when the clinical status or underlying medical condition of the Covered Person requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Alternate Facility setting. Services are limited to Covered Persons who are one of the following:

- A child under seven years of age.
- A person who is developmentally disabled, regardless of age.
- A person whose health is compromised and for whom general anesthesia is required, regardless of age.

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

38. Mastectomy Services

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

39. Orthotic Benefit

Benefits for orthotic devices, including original and replacement devices when devices are prescribed by a Physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license.

40. Osteoporosis Services

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

41. Phenylketonuria (PKU) Treatment

Benefits for the testing and treatment of phenylketonuria (PKU). (Benefits for PKU testing are described under *Preventive Care Services.*) Coverage includes Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specialized in the treatment of metabolic disease. The diet must be needed to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

"Formula" means an enteral product or enteral products for use at home that are prescribed by a Physician for the treatment of phenylketonuria (PKU).

"Special Food Product" means a food product that is both of the following:

- Prescribed by a Physician for the treatment of PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
- Used in place of normal food products, such as grocery store foods, used by the general public.

42. Prosthetic Devices - Laryngectomy

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

43. Specialized Footwear

Special footwear needed as a result of foot disfigurement caused by any of the following:

- Cerebral palsy.
- Arthritis.
- Polio.
- Spina bifida.
- Diabetes.
- Accident.
- Developmental disability.

44. Telehealth Services

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

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

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

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

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

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as described under *Dental Anesthesia Services* in *Section 1: Covered Health Services*.

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

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

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

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

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.

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

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

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

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

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.

3. Cranial banding.

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

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

- Ultrasonic nebulizers.

5. Devices and computers to assist in communication and speech.
6. Oral appliances for snoring.
7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications, except those needed to treat diabetes. This exclusion does not apply to medications which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under *Section 9: Defined Terms* and except that coverage which is provided for an *FDA*-approved drug prescribed for a use that is different from the use for which the *FDA* approved it, when needed for treatment of a chronic and seriously debilitating or life-threatening condition. The drug must appear on the Formulary List, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the *FDA* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.

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

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

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

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

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

7. Shoe orthotics. This exclusion does not apply to shoe orthotics for which Benefits are provided as described under *Specialized Footwear* in *Section 1: Covered Health Services*.

8. Shoe inserts. This exclusion does not apply to shoe inserts for which Benefits are provided as described under *Specialized Footwear* in *Section 1: Covered Health Services*.

9. Arch supports. This exclusion does not apply to arch supports for which Benefits are provided as described under *Specialized Footwear* in *Section 1: Covered Health Services*.

G. Medical Supplies

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

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

   This exclusion does not apply to:

   - Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Services*.
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Treatment* in *Section 1: Covered Health Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.

4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. This exclusion does not apply to conditions defined as Severe Mental Illness and Serious Emotional Disturbances in *Section 9: Defined Terms* of the *Certificate.*

5. Educational/behavioral services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Severe Mental Illness and Serious Emotional Disturbances in *Section 9: Defined Terms* of the *Certificate*.

6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

8. Services or supplies for the diagnosis or treatment of Mental Illness that are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Determined to be an Experimental or Investigational Service.
   - Not consistent with the Mental Health/Substance Use Disorder Designee's clinical protocols. These clinical protocols (as revised from time to time) are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.
   - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition, except as described under *Phenylketonuria (PKU) Treatment* in *Section 1: Covered Health Services*.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods), except as described under *Phenylketonuria (PKU) Treatment* in *Section 1: Covered Health Services*.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.
    - Safety equipment.
    - Treadmills.
    - Vehicle modifications such as van lifts.
    - Video players.
    - Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Gender/sex reassignment surgery is not covered unless the same procedure is allowed in the treatment of another condition, not related to gender identity or gender dysphoria. This exclusion does not permit the denial of coverage if the health care services involved are otherwise available under the Policy, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training. Also, this exclusion does not permit the denial of coverage for health care services

available to a Covered Person of one sex due only to the fact that the Covered Person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, a gender transition.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

10. Biofeedback.

11. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.

12. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer or as described in *Temporomandibular Joint (TMJ) Services* under *Section 1: Covered Health Services*. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.

13. Non-surgical treatment of obesity.

14. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

16. In vitro fertilization regardless of the reason for treatment.

M. Providers

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

2. Services performed by a provider with your same legal residence.

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

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

   This exclusion does not apply to mammography.

N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

P. Substance Use Disorders

Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

3. Educational/behavioral services that are solely focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Severe Mental Illness and Serious Emotional Disturbances in *Section 9: Defined Terms* of the *Certificate.*

4. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Determined to be an Experimental or Investigational Service.
   - Not consistent with the Mental Health/Substance Use Disorder Designee's clinical protocols. These clinical protocols (as revised from time to time) are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.
   - Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Q. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services.*

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

R. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services.*

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

3. Eye exercise or vision therapy.

4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

5. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

If You Are Eligible for Medicare

Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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

Eligible Persons must reside within the United States.

Dependent

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

Coverage begins on the date identified in the Policy if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

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

Coverage begins on the date identified by the Enrolling Group if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if the Enrolling Group receives the benefit election form and any required Premium within 60 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

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

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 60 days of the event that makes the new Dependent eligible.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program in California). Coverage will begin only if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan, including the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program in California). Coverage will begin only if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted

above, coverage will begin only if the Enrolling Group receives the completed benefit election form and any required Premium within 60 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

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

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

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

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

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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