Other Events Ending Your Coverage

When the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

  If UnitedHealthcare Insurance Company can demonstrate you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may rescind your coverage, with 60 days advance written notice of your right to appeal. No Policy will be rescinded after 24 months following the issuance of the Policy. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may cancel your coverage, as permitted by law. Should your coverage be rescinded due to fraud, or an intentional misrepresentation of a material fact, we may take any and all actions allowed by law, which may include demanding that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

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

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed.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**.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of a physically or mentally disabling Injury, illness, or condition.
- Depends chiefly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will notify the Subscriber that the Enrolled Dependent child's coverage will end upon attainment of the limiting age unless the Subscriber submits proof of the criteria described above to us within 60 days of the date of receipt of our notification. We will send this notification to the Subscriber at least 90 days prior to the date the Enrolled Dependent child attains the limiting age. Upon receipt of the request of the Subscriber for continued coverage of the child and proof of the criteria described above, we will determine whether the Enrolled Dependent child meets the criteria before the child attains the limiting age. If we fail to make the determination by that date, coverage of the Enrolled Dependent child will continue pending our determination.

We may continue to ask you for proof that the child continues to be disabled and dependent. However, we will not ask for this information more than once a year after a two-year period following the child's attainment of the limiting age.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

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

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

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

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

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

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

A Qualified Beneficiary is an individual who was covered under the Policy and has also exhausted their continuation coverage under Federal law (COBRA) for which they were entitled to less than 36 months of coverage. Extended continuation coverage under state law (Cal-COBRA) may be obtained for up to 36 months from the date that the COBRA continuation began.

Qualifying Events for Continuation Coverage under State Law (Cal-COBRA)

The date of your "Qualifying Event" is the date that continuation coverage began under your federal COBRA continuation.

Notification Requirements and Election Period for Continuation Coverage under State Law (Cal-COBRA)

Notification of any right to extended coverage under Cal-COBRA will be provided to you by us within 90 days prior to your termination under COBRA. Continuation must be elected within 30 days of when COBRA continuation is scheduled to end.

The Enrolling Group or the Enrolling Group's designated plan administrator will notify you of any annual Benefit or Premium changes that may occur during your Open Enrollment Period.

Termination Events for Continuation Coverage under State Law (Cal-COBRA)

Continuation under the Policy will end on the earliest of the following dates:

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

Conversion

If your coverage terminates for any reason other than the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability. Conversion coverage is not required to be provided to you when the Policy is terminated for any of the following reasons:

- You or the Enrolling Group failed to make any required contributions toward the coverage; or
- The Policy ends and replacement coverage is provided within 60 days of termination.

Conversion coverage is not required to be provided to you if any of the following facts are present:

- You are covered by or are eligible for benefits under title XVIII of the United States Social Security Act;
- You are covered by or are eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
- You are covered for similar benefits by an individual policy or contract.
- You have not been continuously covered under the Policy (or any prior group plan with similar coverage) during the three-month period immediately preceding your termination of coverage.
- Notification of your right to conversion coverage will be provided to you by the Enrolling Group within 15 days of the date of termination.

- Benefits provided under your conversion coverage will be at least the minimum benefits as required for major medical conversion coverage as required by the California Insurance Code.

Application and payment of the initial Premium must be made within 63 days after coverage ends under the Policy. Coverage will be effective on the day following the termination of coverage under the Policy. Conversion coverage will be provided for you and any Enrolled Dependents. Coverage will be issued in accordance with the terms and conditions in effect at the time of application.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

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 below.

You must submit a request for payment of Benefits within 90 days after the date of service. Upon your request, we will provide claims forms to you within 15 days of your request. If you do not request such a claim form, you may submit the required information as provided below. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

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

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

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

We will reimburse claims or any portion of any claim, whether instate or out-of-state, for Covered Health Services, as soon as possible, no later than 30 working days after receipt of the claim.

However, a claim or portion of a claim may be contested or denied by us. In that case you will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested or denied will identify the portion of the claim that is contested or denied and the specific reasons including, for each reason, the factual and legal basis known at the time by us for contesting or denying the claim. If the reason is based solely on facts or solely on law, we will provide only the factual or the legal basis for contesting or denying the claim. We will provide a copy of such notice to each Covered Person who received services pursuant to the claim that was contested or denied and the health care provider that provided the services at issue.

If an uncontested claim is not reimbursed by delivery to your address of record within 30 working days after receipt, we will pay interest at the rate of 10% per annum beginning with the first calendar day after the 30-working-day period.

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

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

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

Section 6: Questions, Complaints and Appeals

IMPORTANT NOTICE - CLAIM DISPUTES

Should a dispute concerning a claim 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) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

A Covered Person 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

For further information about complaint procedures please read the section below.

IMPORTANT NOTICE - NETWORK PROVIDER ACCESSIBILITY COMPLAINTS

If you have a complaint regarding your ability to access Covered Health Services from a Network provider in a timely manner, call *Customer Care* at the telephone number shown on your ID card. If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance.

Call the California Department of Insurance at:

- 1-800-927-HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance

Consumer Communications Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

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

Appeals Determinations

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

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

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Denial of Experimental, Investigational or Unproven Services

If we deny Benefits for a medical procedure or plan of treatment as being Experimental or Investigational Services or Unproven Services and those services are for a Covered Person with a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), we will provide you with written notification of all of the following:

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.
- The specific medical and scientific reasons for the denial and specific references to pertinent Policy provisions upon which the denial is based.

- A description of the alternative medical procedures or treatments covered by the Policy, if any.
- A description of the process of external review explaining how you or your representative can appeal the denial and participate in the review. An external review will be provided to the Covered Person within 30 calendar days following the receipt of a request for external review. An expedited review may be held within 5 business days at the request of the treating Physician.

Federal External Review Program

The *Departments of Health and Human Services, Labor and Treasury* (*Departments*) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, we will provide you with additional information concerning the process.

Contact us at the telephone number shown on your ID card for more information on the Federal external review program.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent Medical Review (IMR) form the California Department of Insurance (CDI) at no cost to you. However, you must first file an appeal of the denial with us.

First Steps: Appeal the denial using our internal appeals/grievance process.

- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

IMR Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IMR request with the California Department of Insurance. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent Medical Review: In this process, expert independent medical professional review the medical decisions made by us and often decide in favor of the Covered Person getting the medical treatment requested.

An IMR can be requested if our decision involves:

- Health claims that have been denied, modified, or delayed by us because a Covered Health Service or treatment was not considered Medically Necessary;
- Health claims that have been denied for urgent or emergency services that a provider recommended was Medically Necessary;
- Health claims that have been denied as being Experimental, Investigational or Unproven Services

The results of an external review requested for Experimental, Investigational or Unproven Services can be rendered in seven days if you suffer from a terminal illness and your Physician requests an expedited review.

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application.

2. Agree and provide written consent to participate in IMR.

3. The CDI determines if the request is eligible for IMR.

4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.

5. The IMR organization will send the decision to the Covered Person, UnitedHealthcare Insurance Company, and the California Insurance Commissioner.

6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify the Covered Person and us. The decision is binding on UnitedHealthcare Insurance Company.

Reviewing Coverage Denials: If we deny treatment as not a Covered Health Service, or if CDI finds that the issue does not involve a disputed health care service, CDI will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

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

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

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

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

   1. Plan includes: group, blanket, franchise and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; medical benefits under group or individual automobile contracts; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

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

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This

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

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order of Benefit Determination Rules

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

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

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

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

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

Effect on the Benefits of This Plan

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

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

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

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

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

Payments Made

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

Right of Recovery

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

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We offer health care coverage to Eligible Persons with a physical handicap under the same terms and conditions as are offered to Eligible Persons without a physical handicap. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

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

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

Our Relationship with Providers and Enrolling Groups

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

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

We are not considered to be an employer 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 with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

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

The *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., does not apply to an employee welfare benefit plan that is a governmental plan. This Policy, as a governmental plan, is exempt from ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

Your Relationship with Providers and Enrolling Groups

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

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount that is a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

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

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, the Enrolling Group is responsible for giving notice to you on a timely basis.

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We will do the following:

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

Other persons or entities may provide services in regard to the administration of the Policy.

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

Administrative Services

We may arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right to change, modify, withdraw or add Benefits subject to the approval of the Enrolling Group. If required by any change in applicable law or regulation, benefits may be modified by us upon 60 days written notice to the Enrolling Group or as soon as reasonably practicable. Such modification to Benefits shall take effect as required by legal mandate. To the extent permitted by law, this Policy may be terminated by us or the Enrolling Group pursuant to the provisions of the Policy.

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

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and approved by Enrolling Group. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.

- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Reimbursement - Right to Recovery

In consideration of the coverage provided by this Certificate of Coverage, we shall have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery from any or all of the following listed below.

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

You agree as follows:

- That you will cooperate with us in protecting our right to reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the reimbursement claim,
  - responding to requests for information about any accident or injuries, and
  - making court appearances.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; and so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.

- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's injury, the terms of this reimbursement clause shall apply to that claim.

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim.*

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

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes 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 Eligible Person 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.

Section 9: Defined Terms

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

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for 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. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Behavioral Health Treatment - professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a Physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the California Business and Professions Code.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
  - A qualified autism service provider.
  - A qualified autism service professional supervised and employed by the qualified autism service provider.
  - A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific Covered Person being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
  - Describes the Covered Person's behavioral health impairments to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Covered Person's progress is evaluated and reported.

- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

In applying the above definition, "qualified autism service provider," qualified autism service professional," and "qualified autism service paraprofessional" shall have the following meanings:

- "Qualified autism service provider" means either of the following:
  - A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
  - A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
- "Qualified autism service professional" means an individual who meets all of the following criteria:
  - Provides Behavioral Health Treatment.
  - Is employed and supervised by a qualified autism service provider.
  - Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
  - Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.
- "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - Is employed and supervised by a qualified autism service provider.
  - Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.
  - Has adequate education, training, and experience, as certified by a qualified autism service provider.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at birth.

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

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

- The applicable Copayment.
- The Eligible Expense.

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

Covered Health Service(s) - 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*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

Enrollment may not be denied based on any of the following facts:

- The child does not reside with the Subscriber.
- The child is born out of wedlock.
- The child is not claimed as a dependent on the Subscriber's federal or state income tax.
- The child lives outside the service area.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

If the Subscriber is required by a court or administrative order to provide health coverage for the Subscriber's child, the child will be able to be enrolled regardless of any enrollment season restriction. We will enroll the child upon application for enrollment submitted to the Enrolling Group by the custodial parent, the non-custodial parent, the Medi-Cal program, or the local child support agency.

We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

- The Enrolling Group receives satisfactory written evidence that the order requiring coverage is no longer in effect.
- The Enrolling Group receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of disenrollment under this Policy.
- The Enrolling Group has eliminated dependent health coverage for all its Subscribers.
- The Subscriber is no longer eligible for coverage.

We will notify both parents and any other person having custody of a child in writing at any time that health insurance for the child is terminated.

When a child is enrolled in a plan of the non-custodial parent or a parent sharing custody or temporary control of the child, we will:

- Provide the custodial parent with any information necessary to obtain Benefits and services for the child under this Policy.
- Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the non-custodial parent.
- Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the Medi-Cal program.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or

conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Domestic Partner - a person who has filed a declaration of domestic partnership with the California Secretary of State or a person who meets the eligibility requirements, as defined by the Enrolling Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
  - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
  - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all provider billings 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 source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (*FDA*) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Copayments for most Covered Health Services do not apply to the Out-of-Pocket Maximum. Coinsurance for Covered Health Services will apply to the Out-of-Pocket Maximum. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any acupuncturist, audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Serious Emotional Disturbances - when a Enrolled Dependent child who has one or more mental disorders as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. As a result of the disorder, one or more of the following is true:

- The child is at risk of removal from home or has been ill for more than six months.
- The child displays psychotic features, risk of suicide or risk of violence.
- The child meets special education eligibility requirements under state law.

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.

Severe Mental Illness - any of the following diagnosed Severe Mental Illnesses: schizophrenia or schizoaffective disorder, bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Telehealth - means the mode of delivering Covered Health Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Health Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Health Services are provided via a telecommunications system or where the asynchronous store and forward service originates.

- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Total Disability or Totally Disabled - A disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

- We may consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

    - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.

    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.

- The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Conversion Provision Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment is part of a legal document (the group Policy), 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 the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 4: When Coverage Ends

The *Conversion* provision in the *Certificate* under *Section 4: When Coverage Ends* and all other references to conversion in *Section 4: When Covered Ends* are deleted.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Clinical Trials and Patient Protection and Affordable Care Act (PPACA) Related 2014 Provision Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below. This Amendment is applicable to Policies issued in the state of California.

Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Any provision of this Amendment which is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Amendment is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

1. Clinical Trials

Benefits for routine patient care costs incurred by a Covered Person when participating in a qualifying clinical trial are required under the *Patient Protection and Affordable Care Act (PPACA)*. The Benefit for *Clinical Trials* and the definition of Experimental or Investigational Service(s) in the *Certificate* are replaced as described below:

Section 1: Covered Health Services

Clinical Trials in Section 1: Covered Health Services is replaced with the following:

Clinical Trials

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

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, 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 qualifying clinical trial as defined by the researcher. With respect to a clinical trial for the treatment of 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.

Routine patient care costs for qualifying clinical trials include:

- With respect to a clinical trial for the treatment of cancer, the costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be Covered Health Services under the Policy if those drugs, items, devices and services were not provided in connection with an approved clinical trial program.
- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational drug, item, device or service, the clinically appropriate monitoring of the effects of the Investigational item or service, or the prevention of complications arising from the provision of the Investigational drug, item, device or service.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational, drug, item, device or service, including the diagnosis of treatment of the complications.

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.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).*)
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*

- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The 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.

With respect to a clinical trial for the treatment of cancer, 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 Covered Person enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.

Section 9: Defined Terms

The definition of Experimental or Investigational Service(s) in Section 9: Defined Terms is replaced with the following:

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

2. Additional Patient Protection and Affordable Care Act (PPACA) Related 2014 Provision

Durable Medical Equipment

Benefits for Durable Medical Equipment are not subject to the annual dollar limit stated in the *Schedule of Benefits*, however Benefits continue to be subject to the limitation of a single purchase of a type of DME (including repair/replacement) every three years.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. **Special Programs**: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance 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. **Prescription Drug Products Prescribed by a Specialist Physician**: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. **NOTE**: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. ***Network Pharmacy*** For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5.00 per Prescription Order or Refill. For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $15.00 per Prescription Order or Refill. For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45.00 per Prescription Order or Refill. ***Non-Network Pharmacy*** For a Tier-1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $5.00 per Prescription Order or Refill. For a Tier-2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $15.00 per Prescription Order or Refill. For a Tier-3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $45.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier-1 Prescription Drug Product: 100% of the

Description and Supply Limits	Benefit (The Amount We Pay)
contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Prescription Drug Charge after you pay a Copayment of $5.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $15.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier-1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $5.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $15.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $45.00 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply. • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For up to a 90-day supply, we pay: For a Tier-1 Prescription Drug Product: 100% of the

Description and Supply Limits	Benefit (The Amount We Pay)
Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.* To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	Prescription Drug Charge after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $30.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $90.00 per Prescription Order or Refill.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider 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 either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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 the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Introduction

Coverage Policies and Guidelines

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

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim.* When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If it is determined that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

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.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products for smoking cessation.

18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)

19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products determined to be Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for formulas and special food products that are prescribed for the treatment of Phenylketonuria (PKU).

23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill.

A Prescription Drug Product includes a drug approved by the U.S. Food and Drug Administration, which is prescribed for a use that is different from the use for which the U.S. Food and Drug Administration approved it, when needed for treatment of a chronic and seriously debilitating or life-threatening condition. The drug must be recognized for the specific treatment 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 Microdex DrugDex;* or (3) it is recommended by two articles from major peer reviewed medical journals. However, there is no coverage for any drug that the U.S. Food and Drug Administration or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

A Prescription Drug Product includes a drug approved by the U.S. Food and Drug Administration prescribed to treat cancer during certain clinical trials as described in the *Certificate of Coverage.*

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

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

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage* (*Certificate*) and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

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

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

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

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

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

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

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26.

During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the policy is permitted, with 60 days advance written notice, only in the following two circumstances:

  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.

- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:

  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

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

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

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a

preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Some Important Information about Appeal and External Review Rights under PPACA

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

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA

(3272). Your state consumer assistance program may also be able to help you. (http://www.dol.gov.ebsa/healthreform/ -click link for Consumer Assistance Programs)

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

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

Mental Health/Substance Use Disorder Parity

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

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

Women's Health and Cancer Rights Act of 1998

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

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

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

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

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

Benefit Determinations

Post-service Claims

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

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

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

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

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

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

Urgent Requests for Benefits that Require Immediate Attention

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

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

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

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

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

Concurrent Care Claims

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

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

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

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

How to Appeal a Claim Decision

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

Your request should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

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

Health Plan Notices of Privacy Practices

Medical Information Privacy Notice

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

PLEASE REVIEW IT CAREFULLY.

Effective September 23, 2013

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

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

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

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

How We Use or Disclose Information

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

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

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

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

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

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

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

- 4. Alcohol and drug abuse;
- 5. Sexually transmitted diseases and reproductive health information; and
- 6. Child or adult abuse or neglect, including sexual assault.

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

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

What Are Your Rights

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

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

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com or www.uhcwest.com.

Exercising Your Rights

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

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

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

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

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

of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective September 23, 2013

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

Information We Collect

We collect personal financial information about you from the following sources:

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions about this Notice

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

[2]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on page XV of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network,*

Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UnitedHealth Group

Health Plan Notice of Privacy Practices: Federal and State Amendments

Revised: June 30, 2013

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

- Show the categories of health information that are subject to these more restrictive laws; and
- Give you a general summary of when we can use and disclose your health information without your consent.

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

Summary of Federal Laws

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

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	MO, NJ, SD
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited	ID, NH, NV

circumstances, and /or (2) to specific recipients.	
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT

Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

ERISA Statement

If the Enrolling Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: County of Riverside Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

County of Riverside
4080 Lemon Street
Riverside, CA 92501
(951) 955-1513

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 95-6000930

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

County of Riverside
4080 Lemon Street
Riverside, CA 92501
(951) 955-1513

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare Insurance Company

185 Asylum Street
Hartford, CT 06103-0450
860-702-5000

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

EXHIBIT C

UnitedHealthcare Select, UnitedHealthcare Insurance Company
Certificate of Coverage for the Plan PVI of County of Riverside

UnitedHealthcare Select

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan PVI

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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UnitedHealthcare Select

UnitedHealthcare Insurance Company

Schedule of Benefits

IMPORTANT NOTICE - LIMITATIONS ON PROVIDER NETWORK AVAILABILITY

Benefits are restricted to Covered Health Services provided by Network providers. Benefits for Covered Heath Services are only provided outside the Service Area when services are provided by a Network provider except for Emergency Health Services and Covered Health Services received at an Urgent Care Center. Benefits for Emergency Health Services received at a non-Network Hospital are described in the *Emergency Health Services - Outpatient* Benefit in this *Schedule of Benefits*.

Enrolled Dependents who do not reside with the Subscriber and live outside the Service Area must see a Network provider in order to obtain Benefits for Covered Health Services, except for Emergency Health Services and Covered Health Services received at an Urgent Care Center as described in this *Schedule of Benefits*.

DIRECTORY OF NETWORK PROVIDERS

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

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

If you have a complaint regarding your ability to access Covered Health Services from a Network provider in a timely manner, call *Customer Care* at the telephone number shown on your ID card. If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance.

Call the California Department of Insurance at:

1-800-927-HELP (1-800-927-4357) if you reside in the State of California

213-897-8921 if you reside outside of the State of California

You may write the California Department of Insurance at:

California Department of Insurance

Consumer Communications Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

Accessing Benefits

Selecting a Primary Physician

You may select a Primary Physician to obtain Network Benefits. A Primary Physician will be able to coordinate all Covered Health Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you may select a Primary Physician for that child.

You may designate a pediatrician as the Primary Physician for an Enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Primary Physician and may seek care directly from any Network obstetrician or gynecologist.

You may change your Primary Physician by contacting *Customer Care* at the telephone number shown on your ID card.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Covered Health Services received at an Urgent Care Center outside your geographic area and Emergency Health Services.

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

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, your Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have

obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

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

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.
- Clinical trials.
- Congenital heart disease surgery.
- Dental anesthesia services.
- Dental services - accidental.
- Obesity surgery.
- Transplants.

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 is not 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 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.	No Annual Deductible.
Out-of-Pocket Maximum	
The Out-of-Pocket Maximum is the maximum amount that you will pay per year which includes 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 excludes Premiums, balance billing amounts for non-Network providers and the Covered Person's spending on non-covered services. 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*. 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.	$1,500 per Covered Person, not to exceed $3,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
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 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% after you pay a Copayment of $15 per visit	Yes	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 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.* 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	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?
the difference and may be billed by the non-Network provider.			
4. Congenital Heart Disease Surgeries			
Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*	100% after you pay a Copayment of $100 per Inpatient Stay	Yes	No
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			
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			
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	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?
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.			
8. Durable Medical Equipment			
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, which are limited to a single purchase (including repair/replacement) every zero years. You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	No	No
9. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.	100% after you pay a Copayment of $100 per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	Yes	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

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
11. Home Health Care			
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			
	100%	No	No
13. Hospital - Inpatient Stay			
	100% after you pay a Copayment of $100 per Inpatient Stay	Yes	No
14. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient **X_Ray and Other Diagnostic Testing - Outpatient**	***Network*** 100% ***Network*** 100%	 No No	 No No
15. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	Network 100%	 No	 No
16. Mental Health Services			
	Inpatient 100% after you pay a Copayment of $100 per Inpatient Stay *Outpatient* 100% after you pay a Copayment of $15 per visit	 Yes Yes	 No No
17. Obesity Surgery			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
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. **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			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described	100% after you pay a Copayment of $15 per visit for a Primary Physician office visit or $15 per visit for a Specialist Physician office visit	Yes	No