

**Plan Document**  
**City Health Plan PPO and Out of Area Plan**

**for Active Members and Retired Members not Eligible for Medicare**

**City and County of San Francisco**

**Group Number: 705287**

**Effective Date: July 1, 2010**

# Table of Contents

<b>Introduction.....</b>	<b>1</b>
How to Use this Document .....	1
Information about Defined Terms.....	1
Your Contribution to the Benefit Costs.....	1
Customer Service and Claims Submittal.....	1
<b>Section 1: What's Covered--Benefits.....</b>	<b>3</b>
Accessing Benefits .....	3
Coinsurance .....	3
Eligible Expenses .....	3
Notification Requirements .....	4
Payment Information .....	6
Annual Deductible.....	6
Out-of-Pocket Maximum .....	6
Lifetime Maximum Plan Benefit.....	6
Benefit Information.....	7
1. Acupuncture Services.....	7
2. Ambulance Services - Emergency only .....	7
3. Dental Services - Accident only.....	8
4. Durable Medical Equipment.....	9
5. Emergency Health Services.....	10
6. Hearing Care.....	11

*To continue reading, go to right column on this page.*

7. Home Health Care.....	12
8. Hospice Care.....	13
9. Hospital - Inpatient Stay .....	14
10. Infertility Services .....	14
11. Injections received in a Physician's Office .....	15
12. Maternity Services.....	16
13. Mental Health Services.....	17
15. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders .....	19
16. Substance Use Disorder Services .....	20
17. Physician's Office Services .....	23
18. Physician's Office Services - Preventive Care.....	24
19. Professional Fees for Surgical and Medical Services .....	24
20. Prosthetic Devices .....	25
21. Reconstructive Procedures .....	26
22. Rehabilitation Services - Outpatient Therapy.....	27
23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services .....	29
24. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy .....	30
25. Transgender Benefit .....	31
26. Transplantation Services .....	32
27. Urgent Care Center Services .....	34
28. Weight Loss Benefit .....	34

## **Section 2: What's Not Covered--Exclusions... 36**

How We Use Headings in this Section .....	36
Plan Exclusions.....	36

*To continue reading, go to left column on next page.*

A. Alternative Treatments.....	36
B. Comfort or Convenience.....	36
C. Dental.....	37
D. Drugs.....	37
E. Experimental or Investigational Services or Unproven Services.....	37
F. Foot Care.....	37
G. Medical Supplies and Appliances.....	37
H. Mental Health or Substance Use.....	38
I. Nutrition.....	39
J. Physical Appearance.....	39
K. Providers.....	40
L. Reproduction.....	40
M. Services Provided under Another Plan.....	40
N. Transplants.....	40
O. Travel.....	41
P. Vision and Hearing.....	41
Q. All Other Exclusions.....	41

**Section 3: Obtaining Benefits ..... 43**

Benefits for Covered Services.....	43
PPO Non-Network Benefits.....	44
Your Responsibility for Notification.....	44
Emergency Health Services.....	45
HealthNotes <sup>SM</sup> .....	45

**Section 4: When Coverage Begins ..... 46**

How to Enroll.....	46
--------------------	----

*To continue reading, go to right column on this page.*

If You Are Hospitalized When Your Coverage Begins.....	46
Who is Eligible for Coverage.....	47
Eligible Person.....	47
Dependent.....	47
When to Enroll and When Coverage Begins.....	48
Initial Enrollment Period.....	48
Open Enrollment Period.....	48
New Eligible Persons.....	48
Adding New Dependents.....	48
Special Enrollment Period.....	50

**Section 5: How to File a Claim ..... 52**

If You Receive Covered Health Services from a Network Provider.....	52
Filing a Claim for Benefits.....	52

**Section 6: Questions and Appeals ..... 55**

What to Do First.....	55
How to Appeal a Claim Decision.....	55
Appeal Process.....	55
Appeals Determinations.....	56
Urgent Claim Appeals that Require Immediate Action.....	56

**Section 7: Coordination of Benefits..... 57**

Benefits When You Have Coverage under More than One Plan.....	57
When Coordination of Benefits Applies.....	57
Definitions.....	57
Order of Benefit Determination Rules.....	59

*To continue reading, go to left column on next page.*

Effect on the Benefits of this Plan.....	60
Right to Receive and Release Needed Information.....	61
Payments Made .....	61
Right of Recovery .....	61

**Section 8: When Coverage Ends..... 62**

General Information about When Coverage Ends.....	62
Events Ending Your Coverage.....	63
The Entire Plan Ends.....	63
You Are No Longer Eligible.....	63
UnitedHealthcare Receives Notice to End Coverage.....	63
Coverage for a Handicapped Child.....	64
Continuation of Coverage.....	64
Continuation Coverage under Federal Law (COBRA) .....	64
Qualifying Events for Continuation Coverage under COBRA .....	65
Notification Requirements and Election Period for Continuation Coverage under COBRA.....	65
COBRA Terminating Events.....	66
Uniformed Services Employment and Reemployment Rights Act.....	68

**Section 9: General Legal Provisions ..... 69**

Plan Document .....	69
Relationship with Providers.....	69
Your Relationship with Providers .....	69
Interpretation of Benefits .....	70
Administrative Services .....	70
Amendments to the Plan .....	70

*To continue reading, go to right column on this page.*

Clerical Error .....	70
Information and Records.....	70
Examination of Covered Persons.....	71
Workers' Compensation not Affected.....	71
Subrogation and Reimbursement.....	71
Refund of Overpayments.....	73
Limitation of Action .....	73

**Section 10: Glossary of Defined Terms ..... 74**

**Outpatient Prescription Drug Benefits ..... 86**

*To continue reading, go to left column on next page.*

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# Introduction

We are pleased to provide you with this Plan Document. This Plan Document describes your Benefits, as well as your rights and responsibilities, under the Plan.

## How to Use this Document

We encourage you to read your Plan Document and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this Plan Document by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this Plan Document and your Benefits work. You should call UnitedHealthcare if you have questions about the limits of the coverage available to you.

Many of the sections of the Plan Document are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your Plan Document and any attachments for your future reference.

Please be aware that your Physician does not have a copy of your Plan Document, and is not responsible for knowing or communicating your Benefits.

## Information about Defined Terms

Because this Plan Document is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your Plan Document.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

## Your Contribution to the Benefit Costs

The Plan may require the Member to contribute to the cost of coverage. Contact the Health Service System for information about any part of this cost you may be responsible for paying.

## Customer Service and Claims Submittal

Please make note of the following information that contains UnitedHealthcare department names and telephone numbers.

**Customer Service Representative** (questions regarding Coverage or procedures): (866)282-0125.

**Personal Health Support<sup>SM</sup>/Notification:** (866)282-0125.

**Mental Health/Substance Use Services – United Behavioral Health:**  
(866)282-0125.

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**Claims Submittal Address:**

United HealthCare Insurance Company  
P. O. Box 30555  
Salt Lake City, Utah 84130-0555

**Requests for Review of Denied Claims and Notice of Complaints:**

United HealthCare Insurance Company  
P. O. Box 659773  
San Antonio, Texas 78265-9773

Internet:

We also encourage you to visit UnitedHealthcare's website, [www.myuhc.com](http://www.myuhc.com), take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Network Physicians in your area.

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# Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Coinsurances and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you to notify Personal Health Support<sup>SM</sup> before you receive them.

## Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits you must see a Network Physician or other Network provider.

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 the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Obtaining Benefits).

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

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

## Coinsurance

Coinsurance is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Coinsurance, see (Section 10: Glossary of Defined Terms). Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service. Please note that PPO Network Coinsurance is calculated as a percentage of a contract rate. PPO Non-Network and Out-of-Area Plan Coinsurance is calculated as a percentage of billed charges in addition to any difference between the amount the provider bills and Eligible Expenses paid by the Plan.

## Eligible Expenses

Eligible Expenses are the amount that we will pay for Benefits once you have met your Annual Deductible. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

We have delegated to UnitedHealthcare the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

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For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For Non-Network Benefits, except for fees that are negotiated by a non-Network provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

## Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying Personal Health Support<sup>SM</sup> before you receive these Covered Health Services.

For Mental Health or Substance Use Services you are responsible for notifying United Behavioral Health.

Services for which you must provide prior notification appear in this section under the *Must You Notify Personal Health Support<sup>SM</sup>?* column in the table labeled *Benefit Information*. Some of the services requiring notification include:

- Accidental Dental Services.
- Durable Medical Equipment/Prosthetic Devices over \$500.
- Home Health Care.
- Hospice Care.
- Hospital Confinements.
- Infertility.
- Weight Loss Treatment.
- Transgender Surgery.

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- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.
- In - Network Mental Health and Substance Use Services.
- Reconstructive Procedures.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

To notify Personal Health Support<sup>SM</sup> or United Behavioral Health, call the Customer Service telephone number on your ID card.

We urge you to confirm with Personal Health Support<sup>SM</sup> that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Personal Health Support<sup>SM</sup>?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental or Investigational Services or Unproven Services exclusion.
- Any other limitation or exclusion of the Plan.

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### *Non-Notification Penalty*

Notification is required for, but is not limited to, the above Services. Failure to comply with the notification requirements will result in a penalty of \$400 per incidence.

### *Special Note Regarding Medicare*

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this Plan Document 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 notify Personal Health Support<sup>SM</sup> before receiving Covered Health Services when Medicare is the primary payer.

**NOTE:** The City Health Plan may cover expenses for certain services that are not covered by Medicare. In these instances, you must follow the notification requirements detailed in this document to avoid applicable penalties.

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## Payment Information

Payment Term	Description	Amounts
<b>Annual Deductible</b>	<p>The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).</p> <p>Covered Expenses charged by both PPO Network and PPO Non-Network providers apply towards both the PPO Network Individual Deductible and the PPO Non-Network Individual Deductible.</p>	<p><u><i>PPO Network</i></u></p> <p>\$250 per Covered Person per Plan Year, not to exceed \$750 for all Covered Persons in a family.</p>
		<p><u><i>PPO Non-Network</i></u></p> <p>\$250 per Covered Person per Plan Year, not to exceed \$750 for all Covered Persons in a family.</p>
		<p><u><i>Out-of-Area Plan</i></u></p> <p>\$250 per Covered Person per Plan Year, not to exceed \$750 for all Covered Persons in a family.</p>
<b>Out-of-Pocket Maximum</b>	<p>The maximum you pay, out of your pocket, in a Plan Year for Coinsurances. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).</p> <p>Covered Expenses charged by both PPO Network and PPO Non-Network providers apply towards both the PPO Network Individual Maximum and the PPO Non-Network Individual Out-of-Pocket Maximum.</p>	<p><u><i>PPO Network</i></u></p> <p>\$3,750 per Covered Person per Plan Year.</p> <p>The Out-of-Pocket Maximum does include the Annual Deductible.</p>
		<p><u><i>PPO Non-Network</i></u></p> <p>\$7,500 per Covered Person per Plan Year.</p> <p>The Out-of-Pocket Maximum does include the Annual Deductible.</p>
		<p><u><i>Out-of-Area Plan</i></u></p> <p>\$3,750 per Covered Person per Plan Year.</p> <p>The Out-of-Pocket Maximum does include the Annual Deductible.</p>
<b>Lifetime Maximum Plan Benefit</b>	<p>The lifetime maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of the Lifetime Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).</p>	<p>\$2,000,000 per Covered Person.</p>

# Benefit Information

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p><b>1. Acupuncture Services</b> Acupuncture services for pain therapy when the service is performed by a provider in the provider's office:</p>	<u>PPO Network</u> No	50%	Yes	Yes
<p>Where such Benefits are available, acupuncture is also a Covered Health Service for the treatment of:</p>	<u>PPO Non-Network</u> No	50%	Yes	Yes
<ul style="list-style-type: none"> <li>• Nausea of Chemotherapy, or</li> <li>• Post-operative nausea, or</li> <li>• Nausea of early Pregnancy.</li> </ul>	<u>Out-of-Area</u> No	50%	Yes	Yes
<p>Any combination of Network and Non-Network Benefits is limited to \$1,000 per Plan Year. All services rendered by an Acupuncturist will count toward the \$1,000 Plan year maximum including but not limited to physical therapy, ultraviolet therapy, massage therapy, not and cold packs, office visits and electric stimulation therapy.</p>				
<p><b>2. Ambulance Services - Emergency only</b> Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed for a serious medical condition or symptoms resulting from injury or sickness which arises suddenly and would put the patient's health in serous jeopardy.</p>	<u>PPO Network</u> No	15%	Yes	Yes
	<u>PPO Non-Network</u> No	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<b>3. Dental Services - Accident only</b>	<u>PPO Network</u>	15%	Yes	Yes
Dental services when all of the following are true:	Yes	15%	Yes	Yes
<ul style="list-style-type: none"> <li>• Treatment is necessary because of accidental damage.</li> <li>• Treatment is necessary because of tumors of the gums.</li> <li>• Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."</li> </ul>				
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:	<u>PPO Non-Network</u> Yes	50%	Yes	Yes
<ul style="list-style-type: none"> <li>• A virgin or unrestored tooth, or</li> <li>• A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.</li> </ul>	<u>Out-of-Area</u> Yes	15%	Yes	Yes
Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.				
<b>Notify Personal Health Support<sup>SM</sup></b>				
Please remember that you should notify Personal Health Support <sup>SM</sup>				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Personal Health Support<sup>SM</sup> can verify that the service is a Covered Health Service. ). If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan for Durable Medical Equipment will be subject to a \$400 increase in your required Coinsurance Amount.</p>				
<p><b>4. Durable Medical Equipment</b> Durable Medical Equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> <li>• Ordered or provided by a Physician for outpatient use.</li> <li>• Used for medical purposes.</li> <li>• Not consumable or disposable.</li> <li>• Not of use to a person in the absence of a disease or disability.</li> </ul>	<p><u><i>PPO Network</i></u> Yes, for items more than \$1,000.</p>	15%	Yes	Yes
<p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment that is consistent with professionally recognized standards of practice.</p>	<p><u><i>PPO Non-Network</i></u> Yes, for items more than \$1,000.</p>	50%	Yes	Yes
<p>Examples of Durable Medical Equipment include:</p> <ul style="list-style-type: none"> <li>• Equipment to assist mobility, such as a standard wheelchair.</li> <li>• A standard Hospital-type bed.</li> <li>• Oxygen concentrator units and the rental of equipment to</li> </ul>	<p><u><i>Out-of-Area</i></u> Yes, for items more than \$1,000.</p>	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>administer oxygen.</p> <ul style="list-style-type: none"> <li>• Delivery pumps for tube feedings.</li> <li>• Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces.</li> <li>• Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.</li> </ul> <p>We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit.</p> <p>Benefits are provided for the replacement of a type of Durable Medical Equipment once every five Plan Years.</p> <p>Personal Health Support<sup>SM</sup> will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Personal Health Support<sup>SM</sup> identifies.</p>				

**Notify Personal Health Support<sup>SM</sup>**

Please remember that you must notify Personal Health Support<sup>SM</sup> before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan for Durable Medical Equipment will be subject to a \$400 increase in your required Coinsurance Amount.

**5. Emergency Health Services**

Services that are required to stabilize or initiate treatment in an

PPO Network

Yes, but only

15%

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.	for an Inpatient Stay.	50% for Non-Emergency		
You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).				
<b>Notify Personal Health Support<sup>SM</sup></b>	<b><u>PPO Non-Network</u></b>	15%	Yes	Yes
To ensure prompt and accurate payment of your claim as a Network Benefit, notify Personal Health Support <sup>SM</sup> within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility.	Yes, but only for an Inpatient Stay.	50% for Non-Emergency		
Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Personal Health Support <sup>SM</sup> within two business days or the same day of admission, or as soon as reasonably possible.	<b><u>Out-of-Area</u></b>	15%	Yes	Yes
If you don't notify Personal Health Support <sup>SM</sup> , Benefits paid by the Plan for the Hospital Inpatient Stay will be subject to a \$400 increase in your required Coinsurance Amount. Benefits will not be reduced for the outpatient Emergency Health Services.	Yes, but only for an Inpatient Stay.	50% for Non-Emergency		
<b>6. Hearing Care</b>	<b><u>PPO Network</u></b>	0%	Yes	Yes
Hearing examinations and associated covered services received from a health care provider in the provider's office.	No			
Benefits are available for charges connected to the purchase or fitting of hearing aids. Benefits are limited to \$2,500 per Covered Person per Plan Year for hearing aids once every 36 months for	<b><u>PPO Non-Network</u></b> No	0%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
either one or both ears.	<u>Out-of-Area</u> No	0%	Yes	Yes
<b>7. Home Health Care</b>	<u>PPO Network</u>			
Services received from a Home Health Agency that are both of the following:	Yes	15%	Yes	Yes
<ul style="list-style-type: none"> <li>• Ordered by a Physician.</li> <li>• Provided by or supervised by a registered nurse in your home.</li> </ul>				
Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.	<u>PPO Non-Network</u> Yes	50%	Yes	Yes
Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:	<u>Out-of-Area</u> Yes	15%	Yes	Yes
<ul style="list-style-type: none"> <li>• It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.</li> <li>• It is ordered by a Physician.</li> <li>• It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.</li> <li>• It requires clinical training in order to be delivered safely and effectively.</li> <li>• It is not Custodial Care.</li> </ul>				
Personal Health Support <sup>SM</sup> will decide if skilled home health care is				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.</p> <p>Any combination of Network and Non-Network Benefits is limited to 120 visits per Plan Year. One visit equals four hours of skilled care services.</p> <p style="text-align: center;"><b>Notify Personal Health Support<sup>SM</sup></b></p> <p>Please remember that you should notify Personal Health Support<sup>SM</sup> five business days before receiving services. If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan will be subject to a \$400 increase in your required Coinsurance Amount.</p>				
<b>8. Hospice Care</b>				
<p>Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and 5 days of respite care. Benefits are available when hospice care is received from a licensed hospice agency.</p>	<u>PPO Network</u>	15%	Yes	Yes
	<u>PPO Non-Network</u>	50%	Yes	Yes
	<u>Out-of-Area</u>	15%	Yes	Yes
<p>Benefits are limited to \$10,000 during each Covered Person's lifetime.</p> <p style="text-align: center;"><b>Notify Personal Health Support<sup>SM</sup></b></p> <p>Please remember that you must notify Personal Health Support<sup>SM</sup> five business days before receiving services. If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan will be subject to a \$400 increase in your required Coinsurance Amount.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<b>9. Hospital - Inpatient Stay</b> Inpatient Stay in a Hospital. Benefits are available for: <ul style="list-style-type: none"> <li>• Services and supplies received during the Inpatient Stay.</li> <li>• Room and board in a Semi-private Room (a room with two or more beds).</li> </ul>	<u>PPO Network</u> Yes	15%	Yes	Yes
<p style="text-align: center;"><b>Notify Personal Health Support<sup>SM</sup></b></p> Please remember that you must notify Personal Health Support <sup>SM</sup> as follows:	<u>PPO Non-Network</u> Yes	50%	Yes	Yes
<ul style="list-style-type: none"> <li>• For elective admissions: five business days before admission.</li> <li>• For non-elective admissions: within one business day or the same day of admission.</li> <li>• For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible.</li> </ul>	<u>Out-of-Area</u> Yes	15%	Yes	Yes
If you don't notify Personal Health Support <sup>SM</sup> , Benefits paid by the Plan will be subject to a Coinsurance reduction of \$400.				
<b>10. Infertility Services</b> Covered Health Services for infertility services and associated expenses including: <ul style="list-style-type: none"> <li>• Diagnosis and treatment of an underlying medical condition which causes infertility when provided by or under the direction</li> </ul>	<u>PPO Network</u> Yes	15% only for Diagnosis  50% for ART	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>of a Physician.</p> <ul style="list-style-type: none"> <li>Up to six natural (intra-cervical) artificial inseminations, three stimulated (intra-uterine) artificial inseminations, and one course of gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or in vitro fertilization (IVF) per lifetime, and any related prescription medication treatment.</li> </ul> <p>Infertility means, the Covered Person must have been unable to become pregnant through more conservative means for a minimum of 12 months, unless one partner has already been diagnosed as infertile.</p>	<u>PPO Non-Network</u> Yes	50% for diagnosis or ART	Yes	Yes
<p>This Benefit will not be covered if</p> <ul style="list-style-type: none"> <li>If infertility is the result of voluntary sterilization.</li> <li>Assisted reproductive technology (ART) services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant.</li> </ul>	<u>Out-of-Area</u> Yes	15% for diagnosis 50% for ART	Yes	Yes
<b>Notify Personal Health Support<sup>SM</sup></b>				
Please remember that you must notify Personal Health Support <sup>SM</sup> . If you don't notify Personal Health Support <sup>SM</sup> , Benefits will not be paid by the Plan.				
<b>11. Injections received in a Physician's Office</b>	<u>PPO Network</u> No	15% per injection	Yes	Yes
Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	<u>PPO Non-Network</u> No	50% per injection	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<b>12. Maternity Services</b>	<u>Out-of-Area</u> No	15% per injection	Yes	Yes
Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.	<u>PPO Network</u> Yes if Inpatient Stay exceeds time frames.	15%	Yes	Yes
There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Personal Health Support <sup>SM</sup> during the first trimester, but no later than one month prior to the anticipated childbirth.	<u>PPO Non-Network</u> Yes if Inpatient Stay exceeds time frames.	50%	Yes	Yes
We will pay Benefits for an Inpatient Stay of at least:	<u>Out-of-Area</u> Yes if Inpatient Stay exceeds time frames.	15%	Yes	Yes
<ul style="list-style-type: none"> <li>• 48 hours for the mother and newborn child following a vaginal delivery.</li> <li>• 96 hours for the mother and newborn child following a cesarean section delivery.</li> </ul>				
If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.				
<b>Notify Personal Health Support<sup>SM</sup></b>				
Please remember that you must notify Personal Health Support <sup>SM</sup> as soon as reasonably possible if the Inpatient Stay for the mother				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
and/or the newborn will be more than the time frames described. If you don't notify Personal Health Support <sup>SM</sup> that the Inpatient Stay will be extended, Benefits will not be paid by the Plan for the extended stay.				
<b>13. Mental Health Services</b>	<u>PPO Network</u>	<u>Hospital</u>		
Mental Health Services including those received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.	Yes. You must call United Behavioral Health to receive the Benefits.	<u>Inpatient Stay</u> 15% <u>Physician's Office Services</u> 15%.	Yes	Yes
Benefits for Mental Health Services include:	<u>PPO Non-Network</u> No	<u>Hospital Inpatient Stay</u> 50% <u>Physician's Office Services</u> 15%.	Yes	Yes
<ul style="list-style-type: none"> <li>• Mental health evaluations and assessment.</li> <li>• Diagnosis.</li> <li>• Treatment planning.</li> <li>• Referral services.</li> <li>• Medication management.</li> <li>• Inpatient services.</li> <li>• Partial hospitalization/day treatment.</li> <li>• Intensive outpatient treatment.</li> <li>• Services at a Residential Treatment Facility.</li> <li>• Individual, family and group therapeutic services.</li> <li>• Crisis intervention.</li> </ul>	<u>Out-of-Area</u> No	<u>Hospital Inpatient Stay</u> 15% <u>Physician's Office Services</u> 15%	Yes	Yes

**Description of Covered Health Service**

**Must You Notify Personal Health Support<sup>SM</sup>?**

**Your Coinsurance Amount**  
 % Coinsurances are based on a percent of Eligible Expenses

**Does Coinsurance Help Meet Out-of-Pocket Maximum?**

**Do You Need to Meet Annual Deductible?**

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating all of your care. Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator. Contact the Mental Health/Substance Use Disorder Administrator regarding Benefits for Mental Health Services.

**Special Mental Health Programs and Services**

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

**Description of Covered Health Service**

**Must You Notify Personal Health Support<sup>SM</sup>?**

**Your Coinsurance Amount**  
% Coinsurances are based on a percent of Eligible Expenses

**Does Coinsurance Help Meet Out-of-Pocket Maximum?**

**Do You Need to Meet Annual Deductible?**

pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

**Authorization Required**

Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Use Disorder Administrator. The Mental Health/Substance Use Disorder Administrator phone number appears on your ID card.

Without authorization, you will be responsible for paying all charges and no Benefits will be paid.

**15. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders**

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment

PPO Network

Yes. You must call United Behavioral Health to receive the Benefits.

PPO Non-Network

No

Hospital Inpatient Stay

15%

Physician's Office Services

15%.

Yes

Yes

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available as described under the Enhanced Autism Spectrum Disorders benefit below.</p> <p>Benefits include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluations and assessment.</li> <li>• Treatment planning.</li> <li>• Referral services.</li> <li>• Medical management.</li> <li>• Inpatient/24-hour supervisory care.</li> <li>• Partial Hospitalization/Day Treatment.</li> <li>• Intensive Outpatient Treatment.</li> <li>• Services at a Residential Treatment Facility.</li> <li>• Individual, family, therapeutic group and provider-based case management services.</li> <li>• Psychotherapy, consultation and training session for parents and paraprofessional and resource support to family.</li> <li>• Crisis intervention.</li> <li>• Transitional care.</li> </ul>	<p><u>Out-of-Area</u> No</p>			
<p><b>16. Substance Use Disorder Services</b> Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's</p>	<p><u>PPO Network</u> <u>Yes. You must call United Behavioral</u></p>	<p><u>Hospital Inpatient Stay</u> 15% <u>Physician's</u></p>	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>office or at an Alternate Facility.</p> <p>Benefits for Substance Use Disorder Services include:</p> <ul style="list-style-type: none"> <li>• Substance Use Disorder or chemical dependency evaluations and assessment;</li> <li>• Diagnosis;</li> <li>• Treatment planning;</li> <li>• Detoxification (sub-acute/non-medical);</li> <li>• Inpatient services;</li> <li>• Partial Hospitalization/Day Treatment;</li> <li>• Intensive Outpatient Treatment;</li> <li>• Services at a Residential Treatment Facility;</li> <li>• Referral services;</li> <li>• Medication management;</li> <li>• Individual, family and group therapeutic services; and</li> <li>• Crisis intervention.</li> </ul>	<u>Health to receive the Benefits.</u>	<u>Office Services</u> 15%.	Yes	Yes
<p>Referrals to a Substance Use Disorder provider are at the sole discretion of the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating all of your care. Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator.</p>	<u>PPO Network</u> No	15%	Yes	Yes
	<u>PPO Non-</u>			

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Contact the Mental Health/Substance Use Disorder Administrator regarding Benefits for Substance Use Disorder Services.	<u>Network</u> No	50%	Yes	Yes

**Special Substance Use Disorder Programs and Services**

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

**Authorization Required**

Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Use Disorder Administrator. The Mental Health/Substance Use Disorder Administrator phone number appears on your ID card.

Without authorization, you will be responsible for paying all charges

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
and no Benefits will be paid.				
Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under <i>Professional Fees for Surgical and Medical Services</i> below.	<u>Out-of-Area</u> No	15%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.				
<b>Notify Personal Health Support<sup>SM</sup></b>				
Please remember that you should notify Personal Health Support <sup>SM</sup> for Magnetic Resonance Imaging (MRI) before receiving services from a Non-Network provider. If you don't notify Personal Health Support <sup>SM</sup> , Benefits paid for by the Plan will be subject to a \$400 increase in your required Coinsurance Amount. It is your responsibility to notify Personal Health Support <sup>SM</sup> . Your doctor will not do this on your behalf.				
<b>17. Physician's Office Services</b>				
Covered Health Services received at home or in a Physician's office:				
<ul style="list-style-type: none"> <li>Treatment of a Sickness or Injury.</li> </ul>	<u>PPO Network</u> No	15%	Yes	Yes
	<u>PPO Non-Network</u> No	50%	Yes	Yes
	<u>Out-of-Area</u> No	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<b>18. Physician's Office Services - Preventive Care</b>	<u>PPO Network</u> No	15%  0% for immunizations	Yes	Yes
Covered Health Services received in a Physician's office for preventive care including:				
<ul style="list-style-type: none"> <li>• Well-baby and well-child care.               <ul style="list-style-type: none"> <li>— Well baby care - 10 visits to age 2</li> <li>— One exam per Plan Year including lab and x-rays and immunizations after age 2, Network only.</li> </ul> </li> <li>• Adult Preventive medical care.               <ul style="list-style-type: none"> <li>— One exam per Plan Year including lab and x-rays, immunizations, vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment.). This Benefit applies only to PPO Network and the Out-of-Area Plan. If you go to a PPO Non-Network provider, routine exams are not covered.</li> </ul> </li> <li>• Routine well woman, including pap smears, pelvic examinations and mammograms.</li> <li>• Voluntary family planning.</li> </ul>	<u>PPO Non-Network</u> No	50%	Yes	Yes
	<u>Out-of-Area</u> No	15%  0% for immunizations	Yes	Yes
<b>19. Professional Fees for Surgical and Medical Services</b>	<u>PPO Network</u> No	15%	Yes	Yes
Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient	<u>PPO Non-Network</u>	50%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Rehabilitation Facility or Alternate Facility.  When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.	No	15%	Yes	Yes
<b>20. Prosthetic Devices</b> Prosthetic devices that replace a limb or body part including: <ul style="list-style-type: none"> <li>• Artificial limbs.</li> <li>• Artificial eyes.</li> <li>• Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.</li> <li>• Shoe orthotics - one pair per Plan Year.</li> <li>• Shoe inserts - three pairs per Plan Year.</li> </ul>	<u>PPO Network</u> Yes, for items more than \$500.	15%	Yes	Yes
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.	<u>PPO Non-Network</u> Yes, for items more than \$500.	50%	Yes	Yes
The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five Plan Years.	<u>Out-of-Area</u> Yes, for items more than \$500.	15%	Yes	Yes

**Notify Personal Health Support<sup>SM</sup>**

Please remember that you must notify Personal Health Support<sup>SM</sup> before obtaining any single item of Prosthetic Device that costs

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>more than \$500. If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan for the Prosthetic Device will be subject to a \$400 increase in your required Coinsurance Amount.</p>				
<p><b>21. Reconstructive Procedures</b> Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.</p>	<p><u>PPO Network</u> Yes</p>	<p>15%</p>	<p>Yes</p>	<p>Yes</p>
<p>Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.</p>	<p><u>Out-of-Area</u> Yes</p>	<p>15%</p>	<p>Yes</p>	<p>Yes</p>
<p>Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to</p>				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.</p> <p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact Personal Health Support<sup>SM</sup> at the telephone number on your ID card for more information about Benefits for mastectomy-related services.</p> <p style="text-align: center;"><b>Notify Personal Health Support<sup>SM</sup></b></p> <p>Please remember that you should notify Personal Health Support<sup>SM</sup> five business days before receiving services. When you provide notification, Personal Health Support<sup>SM</sup> can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.</p>				
<p><b>22. Rehabilitation Services - Outpatient Therapy</b></p>	<p><u>PPO Network</u> No</p>	<p>15%</p>	<p>Yes</p>	<p>Yes</p>
<p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> <li>Physical therapy.</li> </ul>	<p><u>PPO Non-Network</u></p>	<p>50%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> <li>Occupational therapy.</li> <li>Speech therapy.</li> <li>Pulmonary rehabilitation therapy.</li> <li>Cardiac rehabilitation therapy.</li> </ul>	No			
<p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p>	<u>Out-of-Area</u>			
	No	15%	Yes	Yes
<p>Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.</p>				
<p>Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.</p>				
<p>Any combination of Network and Non-Network Benefits is limited as follows:</p>				
<ul style="list-style-type: none"> <li>Total of 60 visits for any combination of the following per Plan Year. <ul style="list-style-type: none"> <li>— 60 visits of physical therapy per Plan Year.</li> <li>— 60 visits of occupational therapy per Plan Year.</li> </ul> </li> <li>Speech therapy is limited to 60 visits per Plan Year.</li> <li>Pulmonary rehabilitation therapy limited to \$2,500 per lifetime.</li> <li>Cardiac rehabilitation therapy limited to \$2,500 per lifetime.</li> </ul>				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p><b>23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b></p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> <li>• Services and supplies received during the Inpatient Stay.</li> <li>• Room and board in a Semi-private Room (a room with two or more beds).</li> </ul> <p>Any combination of Network and Non-Network Benefits is limited to 120 days per Plan Year.</p> <p>Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.</p> <p>The Covered Person is expected to improve to a predictable level of recovery.</p> <p>Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).</p> <p>Benefits are NOT available for custodial, domiciliary or maintenance</p>	<p><u>PPO Network</u> Yes</p>	<p>15%</p>	<p>Yes</p>	<p>Yes</p>
	<p><u>PPO Non-Network</u> Yes</p>	<p>50%</p>	<p>Yes</p>	<p>Yes</p>
	<p><u>Out-of-Area</u> Yes</p>	<p>15%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

**Notify Personal Health Support<sup>SM</sup>**

Please remember that you must notify Personal Health Support<sup>SM</sup> as follows:

- For elective admissions: five business days before admission.
- For non-elective admission: within one business day or the same day of admission.
- For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible.

If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan will be subject to a \$400 increase in your required Coinsurance Amount.

**24. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy**

PPO Network  
No

50%

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Network or non-Network Spinal Treatment provider in the provider's office.				
Benefits include diagnosis and related services and are limited to one visit and treatment per day.	<u>PPO Non-Network</u> No	50%	Yes	Yes
Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to \$1,000 per Plan Year.	<u>Out-of-Area</u> No	50%	Yes	Yes
<b>25. Transgender Benefit</b>				
Covered Health Services for the following Transgender Benefits when ordered by a Physician.	<u>PPO Network</u> Yes	15%	Yes	Yes
<ul style="list-style-type: none"> <li>• Psychotherapy for gender identity disorders. See Mental Health and Substance Use Services - Outpatient for visit limit.</li> </ul>	<u>PPO Non-Network</u> Yes	50%	Yes	Yes
<ul style="list-style-type: none"> <li>• Pre- and post-surgical hormone therapy.</li> <li>• Surgery subject to the following requirement: <ul style="list-style-type: none"> <li>— The surgery must be performed by qualified provider.</li> <li>— The treatment plan must conform to HBGDA (Harry Benjamin International Gender Dysphoria Association)</li> </ul> </li> </ul>	<u>Out-of-Area</u> Yes	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>standards.</p> <p>— You or your physician must notify Personal Health Support for any surgery.</p> <ul style="list-style-type: none"> <li>The surgical, hospital and laboratory benefits are subject to a \$75,000 lifetime maximum.</li> </ul>				
<b>Notify Personal Health Support<sup>SM</sup></b>				
<p>You must notify Personal Health Support<sup>SM</sup> as soon as the possibility of a transgender surgical benefit arises. If you don't notify Personal Health Support<sup>SM</sup>, Benefits paid by the Plan will be subject to a \$400 increase in your required Coinsurance Amount.</p>				
<b>26. Transplantation Services</b>				
<p>Covered Health Services for organ and tissue transplants when ordered by a Network Physician. For the highest level of Benefits, services must be received at a Designated United Resource Network Facility Transplantation. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be an Experimental or Investigational Service or an Unproven Service. Examples of transplants for which Benefits are available include but are not limited to the transplants listed below.</p>	<u>PPO Network</u> Yes	15%	Yes	Yes
<p>Personal Health Support<sup>SM</sup> notification is required for all transplant services.</p>	<u>PPO Non-Network</u> Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.
<ul style="list-style-type: none"> <li>Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the</li> </ul>	<u>Out-of-Network</u>			

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of \$25,000 is payable for all charges made in connection with the search.</p>	Yes	15%	Yes	Yes
<ul style="list-style-type: none"> <li>• Heart transplants.</li> <li>• Heart/lung transplants.</li> <li>• Lung transplants.</li> <li>• Kidney transplants.</li> <li>• Kidney/pancreas transplants.</li> <li>• Liver transplants.</li> <li>• Liver/small bowel transplants.</li> <li>• Pancreas transplants.</li> <li>• Small bowel transplants.</li> </ul>				
<p>Benefits for cornea transplants that are provided by a Network Physician at a Network Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits.</p>				
<p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health Support<sup>SM</sup> to be a proven procedure for the</p>				

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount <small>% Coinsurances are based on a percent of Eligible Expenses</small>	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
involved diagnoses.				
Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Personal Health Support <sup>SM</sup> at the telephone number on your ID card for information about these guidelines.				
The lifetime maximum for all Transplant Benefits is \$250,000 per Covered Person.				
<b>Notify Personal Health Support<sup>SM</sup></b>				
You must notify Personal Health Support <sup>SM</sup> as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Personal Health Support <sup>SM</sup> , Benefits paid by the Plan will be subject to a \$400 increase in your required Coinsurance Amount.				
<b>27. Urgent Care Center Services</b>	<u>PPO Network</u>			
Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <i>Physician's Office Services</i> earlier in this section.	No	15%	Yes	Yes
	<u>PPO Non-Network</u>			
	No	50%	Yes	Yes
	<u>Out-of-Area</u>			
	No	15%	Yes	Yes
<b>28. Weight Loss Benefit</b>	<u>PPO Network</u>			
Covered Health Services for weight loss when received from a	Yes	50%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support <sup>SM</sup> ?	Your Coinsurance Amount % Coinsurances are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>health care provider.</p> <p>There is a lifetime maximum of \$1,000 per Covered Person.</p>	<p><u>PPO Non-Network</u> Yes</p>	<p>50%</p>	<p>Yes</p>	<p>Yes</p>
<p><b>Notify Personal Health Support<sup>SM</sup></b> You must notify Personal Health Support<sup>SM</sup>. Without authorization, you will be responsible for paying all charges and no Benefits will be paid by the Plan.</p>	<p><u>Out-of-Area</u> Yes</p>	<p>50%</p>	<p>Yes</p>	<p>Yes</p>

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## Section 2: What's Not Covered-- Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Plan.

### How We Use Headings in this Section

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

### Plan Exclusions

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

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

*To continue reading, go to right column on this page.*

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

### A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage therapy unless part of a chiropractic care/spinal manipulation service.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
7. Services received by a naturopath or a naturalist.
8. Holistic or homeopathic care.

### B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners.
  - Air purifiers and filters.
  - Batteries and battery chargers.
  - Dehumidifiers.
  - Humidifiers.

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6. Devices and computers to assist in communication and speech.
7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

## C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
  - Transplant preparation.
  - Initiation of immunosuppressives.
  - The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

## D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.

*To continue reading, go to right column on this page.*

4. Over the counter drugs and treatments.

## E. Experimental or Investigational Services or Unproven Services

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

## F. Foot Care

1. Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses).
  - Nail trimming, cutting, or debriding.
2. Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.
  - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.

## G. Medical Supplies and Appliances

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

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2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Ace bandages.
  - Gauze and dressings.
  - Syringes.
  - Diabetic test strips.
3. Orthotic appliances that straighten or re-shape a body part, other than shoe orthotics.
4. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

## H. Mental Health or Substance Use

1. inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Use Disorder (MH/SUD) Administrator;
2. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
3. services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective;
4. treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Mental Health/Substance Use Disorder Administrator;
5. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

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- not consistent with generally accepted standards of medical practice for the treatment of such conditions;
- not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
- typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;
- not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
- not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

6. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
7. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
8. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or

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abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SUD Administrator;

9. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
10. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
11. learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
12. mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
13. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
14. Substance Use Disorder Services for the treatment of nicotine or caffeine use;
15. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders;
16. routine use of psychological testing without specific authorization; and
17. pastoral counseling.

## I. Nutrition

1. Megavitamin and nutrition based therapy.

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2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling*, nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

## J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.  
**Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. This includes the cost of purchase or rental of exercise equipment.

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4. Commercial or other weight loss programs whether or not they are under medical supervision. Commercial or other weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

## K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an Member or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

## L. Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.
3. Fees or direct payment to a donor for sperm or ovum donations.
4. Monthly fees for maintenance and/or storage of frozen embryos.

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## M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

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

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

## N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits) when UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services for transplants involving mechanical or animal organs.
3. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits), unless determined by Personal Health Support<sup>SM</sup> to be a proven procedure for the involved diagnoses.

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## O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel, meals, lodging or other transportation expenses, even though prescribed by a Physician.

## P. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Cochlear implant.
5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

## Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
  - Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research.
  - Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Coinsurances and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Coinsurances and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
11. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
12. Growth hormone therapy.
13. Custodial Care.
14. Domiciliary care.
15. Private duty nursing.

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16. Rest cures.
17. Psychosurgery.
18. Treatment of benign gynecomastia (abnormal breast enlargement in males).
19. Medical and surgical treatment of excessive sweating (hyperhidrosis).
20. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
21. Appliances for snoring.
22. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
23. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
24. Any charge for services, supplies or equipment advertised by the provider as free.
25. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
26. Any charges prohibited by federal anti-kickback or self-referral statutes.
27. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
28. Speech therapy to treat stuttering, stammering, or other articulation disorders.

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# Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Services.
- Your responsibility for notification.
- Emergency Health Services.

## Benefits for Covered Services

For the PPO Plan, Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a Network Physician or other Network provider.
- Emergency Health Services.
- Covered Health Services that are described as Network Benefits in (Section 1: What's Covered--Benefits).

Please note that in-network Mental Health and Substance Use Services must be authorized by United Behavioral Health. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Use*.

*To continue reading, go to right column on this page.*

## Comparison of Network and Non-Network Benefits

	Network	Non-Network
<b>Benefits</b>	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
<b>Who Should Notify Personal Health Support<sup>SM</sup></b>	You must notify Personal Health Support <sup>SM</sup> for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the <i>Must You Notify Personal Health Support<sup>SM</sup>?</i> column.	
<b>Who Should File Claims</b>	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).
<b>Outpatient Emergency Health Services</b>	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network).	

### ***If you are in the Out-of-Area Plan:***

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider and are generally paid at the in-network benefit level even if the provider is not in the network. Please note that the Out-of-Area Plan Coinsurance is based on Eligible Expenses which may result in higher out-of-pocket expenses than the Network PPO Plan.

*To continue reading, go to left column on next page.*

Whenever possible, however, you are encouraged to use in-network providers. The cost of such services will be lower than for out-of-network providers. Therefore, your Coinsurance, which is a percentage of covered (eligible) charges, will be lower as well.

### ***Provider Network***

UnitedHealthcare or its affiliate arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our Members or Members of UnitedHealthcare. It is your responsibility to select your provider. You may request a directory of providers at no cost to you. Provider directories are always available on [www.myuhc.com](http://www.myuhc.com).

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

You can obtain information on Network providers at no cost to you. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network Provider. You can verify the provider's status by calling UnitedHealthcare.

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

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers agree to provide only certain Covered Health Services, but not all Covered Health

*To continue reading, go to right column on this page.*

Services. Some Network providers choose to be a Network provider for only some products. Contact UnitedHealthcare for assistance.

### ***Designated United Resource Network Facilities and Other Providers***

If you have a medical condition that Personal Health Support<sup>SM</sup> believes needs special services, they may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support<sup>SM</sup> may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated United Resource Network Facility or other provider chosen by Personal Health Support<sup>SM</sup>.

## **PPO Non-Network Benefits**

PPO Non-Network Benefits are paid at a lower level than Network Benefits. PPO Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network providers. PPO Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities.

## **Your Responsibility for Notification**

You must notify Personal Health Support<sup>SM</sup> before getting certain Covered Health Services from Network, non-Network and Out-of-Area providers. The details are shown in the *Must You Notify Personal Health Support<sup>SM</sup>?* column in (Section 1: What's Covered--Benefits). If you fail to notify Personal Health Support<sup>SM</sup>, Benefits are reduced or denied.

*To continue reading, go to left column on next page.*

Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

### ***Personal Health Support***<sup>SM</sup>

When you notify Personal Health Support<sup>SM</sup> as described above, they will work with you to implement the Personal Health Support<sup>SM</sup> process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

## **Emergency Health Services**

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

- If you are confined in a non-Network Hospital after you receive Emergency Health Services, Personal Health Support<sup>SM</sup> must be notified within two business days or on the same day of admission if reasonably possible. Personal Health Support<sup>SM</sup> 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 Personal Health Support<sup>SM</sup> decides a transfer is medically appropriate, PPO Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

### **HealtheNotes**<sup>SM</sup>

The Claims Administrator provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications,

*To continue reading, go to right column on this page.*

potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

The Claims Administrator makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

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## Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

### How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Plan Administrator or its designee will give the necessary forms to you along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

### If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that

Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network Providers.

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## Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
<b>Eligible Person</b>	Eligible Person refers to an Employee who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Member. For a complete definition of Eligible Person and Member, see (Section 10: Glossary of Defined Terms).	The Plan Administrator determines who is eligible to enroll under the Plan.
<b>Dependent</b>	<p>Dependent generally refers to the Member's spouse, domestic partner or child(ren). When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p>	The Plan Administrator determines who qualifies as a Dependent.

## When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<b>Initial Enrollment Period</b> The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their eligible Dependents.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the date the Eligible Person becomes eligible to enroll.
<b>Open Enrollment Period</b>	Eligible Persons may enroll themselves and their eligible Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives a completed enrollment form and any required documentation by the Open Enrollment deadline.
<b>New Eligible Persons</b>	New Eligible Persons may enroll themselves and their eligible Dependents.	Coverage begins on the day immediately following the completion of the pay period in which a completed application and all required documentation is received by the Plan Administrator, provided that all documentation is received within 30 days of the Eligible Persons initial eligibility date.
<b>Adding New Dependents</b>	Members may enroll Dependents who join their family because of any of the following events: <ul style="list-style-type: none"><li>• Birth.</li><li>• Legal adoption.</li></ul>	Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the event that makes the new Dependent eligible.

When to Enroll	Who Can Enroll	Begin Date
	<ul style="list-style-type: none"> <li>• Placement for adoption.</li> <li>• Marriage.</li> <li>• Legal guardianship.</li> <li>• Court or administrative order.</li> </ul>	<p>You must enroll your newborn child. If you do not enroll a newborn child, that child is not covered even if you have coverage for other children.</p>

### Special Enrollment Period

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

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights.

Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.

A special enrollment period applies:

- to an Eligible Person and any Dependents when one of the following events occurs:
- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period;
- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must notify the Plan Administrator within 60 days of determination of subsidy eligibility);
- Termination of your or your Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- You or your Dependent become eligible for a

**Event Takes Place** (for example, a birth, marriage or determination of eligibility for state subsidy). Unless otherwise noted under the “Who Can Enroll” column, coverage begins on the date of the event if the Plan Administrator receives the completed enrollment information and any required contribution within 31 days of the event.

**Missed Initial Enrollment Period or Open Enrollment Period.** Unless otherwise noted under the “Who Can Enroll” column, coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

When to Enroll	Who Can Enroll	Begin Date
	<p>premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility); and</p> <ul style="list-style-type: none"> <li>• Coverage under the prior plan ended because of any of the following: <ul style="list-style-type: none"> <li>— Loss of eligibility (including, without limitation, legal separation, divorce or death).</li> <li>— The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.</li> <li>— In the case of COBRA continuation coverage, the coverage ended.</li> <li>— The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.</li> <li>— The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.</li> <li>— An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.</li> </ul> </li> </ul>	

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## Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing 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 other than the Annual Deductible or your Coinsurance amount, contact UnitedHealthcare. You are responsible for meeting the Annual Deductible and for paying the Coinsurance to a Network provider.

### Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through UnitedHealthcare. You must file the claim in a format that contains all of the information required, as described below.

*To continue reading, go to right column on this page.*

You must submit a request for payment of Benefits within one year after the date of service. If a non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. 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, in our or UnitedHealthcare's discretion. 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.

If a Member provides written authorization to allow direct payment to a provider, 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 Member. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

### *Pharmacy Benefit Claims*

If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim.

If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact us by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

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### ***Required Information***

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

- A. Member's name and address.
- B. The patient's name, age and relationship to the Member.
- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
  - Patient Diagnosis
  - Date(s) of service
  - Procedure Code(s) and descriptions of service(s) rendered
  - Charge for each service rendered
  - Provider of service Name, Address and Tax Identification Number
- E. The date the Injury or Sickness began.
- F. 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).

### ***Payment of Benefits***

Through UnitedHealthcare, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- A. The provider notifies UnitedHealthcare that your signature is on file, assigning benefits directly to that provider.
- B. You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

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### ***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 UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare 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, UnitedHealthcare 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.

#### ***Pre-Service Claims***

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from UnitedHealthcare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify

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you of the information needed within 15 days after the claim was received, 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, UnitedHealthcare 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 days 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.

### ***Urgent Claims that Require Immediate Action***

Urgent Care Claims are those claims that require notification or approval 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 UnitedHealthcare receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

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

*To continue reading, go to right column on this page.*

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

- UnitedHealthcare's 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 Care Claim 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. UnitedHealthcare 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 Care Claim 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 claim and decided according to post-service or pre-service timeframes, whichever applies.

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## Section 6: Questions and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

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

### What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service 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 in (How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of UnitedHealthcare.

*To continue reading, go to right column on this page.*

If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

### How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact UnitedHealthcare 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 UnitedHealthcare 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. UnitedHealthcare (first level appeals) and the Plan Administrator (second level appeals)

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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 written 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.

## Appeals Determinations

### Pre-Service and Post-Service Claim Appeals

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

For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by us 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 defined in How to File a Claim), the first level appeal will be conducted and you will be notified by UnitedHealthcare 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 by us of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of UnitedHealthcare, you have the right to request a second level appeal from us as the Plan Administrator. Your second level appeal

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request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that our decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

## Urgent Claim 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 UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.

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# Section 7: Coordination of Benefits

- This section provides you with information about:
- What you need to know when you have coverage under more than one plan.
  - Definitions specific to Coordination of Benefit rules.
  - Order of payment rules.

## Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan 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 benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some

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expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

## Definitions

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

1. "Coverage Plan" is any of the following that provides Benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
  - a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare or other governmental Benefits, as permitted by law.
  - b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; Benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

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

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

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

3. "Allowable Expense" means a health care service or expense, including deductibles and Coinsurances, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides Benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care and outpatient prescription drugs are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:
  - a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
  - b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the

usual and customary fees for a specific benefit is not an Allowable Expense.

- c. If a person is covered by two or more Coverage 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.
  - d. If a person is covered by one Coverage Plan that calculates its Benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
  - e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
  5. "Closed Panel Plan" is a Coverage Plan that provides health Benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.
  6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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## Order of Benefit Determination Rules

When two or more Coverage Plans pay Benefits, the rules for determining the order of payment are as follows:

- A. The Primary Coverage Plan pays or provides its Benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.
- B. A Coverage Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical Benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide Non-Network Benefits.
- C. A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to that other Coverage Plan.
- D. The first of the following rules that describes which Coverage Plan pays its Benefits before another Coverage Plan is the rule to use.
  1. This Plan will always be secondary to medical payment coverage or personal injury protection (PIP) coverage under a any auto liability or no-fault insurance policy.
  2. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, subscriber or retiree is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and

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primary to the Coverage Plan covering the person as other than a Dependent (e.g. a retired Member); then the order of Benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an Member, subscriber or retiree is secondary and the other Coverage Plan is primary.

3. Child Covered Under More Than One Coverage Plan. The order of Benefits when a child is covered by more than one Coverage Plan is:
  - a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
    - 1) The parents are married;
    - 2) The parents are not separated (whether or not they ever have been married); or
    - 3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
  - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Plan Years commencing after the Coverage Plan is given notice of the court decree.
  - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:
    - 1) The Coverage Plan of the custodial parent;
    - 2) The Coverage Plan of the spouse of the custodial parent;

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- 3) The Coverage Plan of the noncustodial parent; and then
  - 4) The Coverage Plan of the spouse of the noncustodial parent.
4. Active or inactive Member. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
  5. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.
  6. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
  7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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## **Effect on the Benefits of this Plan**

- A. When this Coverage Plan is secondary, it may reduce its Benefits by the total amount of Benefits paid or provided by all Coverage Plans Primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:
  1. Determine its obligation to pay or provide Benefits under its contract;
  2. Determine the difference between the Total Allowable Expenses and the benefit payments that the Primary Coverage Plan(s) paid.

If there is a difference between the total Allowable Expenses and the benefit payments that the Primary Coverage Plan(s) paid, this Coverage Plan will pay that amount, less any applicable deductible and Coinsurance requirements of the Coverage Plan.
- B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage 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 for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person

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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 Coverage Plan and other Coverage Plans. UnitedHealthcare may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming Benefits.

UnitedHealthcare need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Coverage 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

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to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

## Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage 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 Coverage 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.

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## Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

### General Information about When Coverage Ends

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, claims will still be paid for Covered Health Services that you received before your coverage ended. However, once your coverage ends, the Plan does not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends or sooner if the Member chooses to end the Dependent's coverage or as otherwise set forth in this Plan Document.

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## Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
<b>The Entire Plan Ends</b>	Your coverage ends on the date the Plan ends.
<b>You Are No Longer Eligible</b>	Your coverage ends on the date you are no longer eligible to be a Member or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Member", "Dependent" and "Enrolled Dependent."
<b>UnitedHealthcare Receives Notice to End Coverage</b>	Your coverage ends on the date UnitedHealthcare receives notice from the Plan Administrator instructing them to end your coverage.

## Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap 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 mental retardation or physical handicap.
- Depends mainly on the Member for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish the Health Service System with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age.

The Health Service System may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of the Health Service System's request as described above, coverage for that child will end.

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## Continuation of Coverage

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

## Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Member.
- A Member's Enrolled Dependent, including with respect to the Member's children, a child born to or placed for adoption with the Member during a period of continuation coverage under federal law.

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- A Member's former spouse.

## Qualifying Events for Continuation Coverage under COBRA

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to a Member who is a Qualified Beneficiary are:

- Termination of employment with us, for any reason other than gross misconduct; and
- Reduction in the Member's hours of employment.

With respect to a Member's spouse or Dependent child who is a Qualified Beneficiary, the qualifying events are:

- Termination of the Member's employment (for reasons other than the Member's gross misconduct); or
- Reduction in the Member's hours of employment; or
- Death of the Member; or
- Divorce or legal separation of the Member; or
- Loss of eligibility by an Enrolled Dependent who is a child; or
- Entitlement of the Member to Medicare benefits; or
- The Plan Sponsor's commencement of a bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired Member and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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## Notification Requirements and Election Period for Continuation Coverage under COBRA

### *Notification Requirements for Qualifying Event*

The Member or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the date of the Member's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent; the date the Qualified Beneficiary would lose coverage under the Plan; or the date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice. A Member or other Qualified Beneficiary must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If the Member or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Member is continuing coverage under federal law, the Member must notify the Plan Administrator within 60 days of the birth or adoption of a child.

### *Notification Requirements for Disability Determination or Change in Disability Status*

The Member or other Qualified Beneficiary must notify the Plan Administrator as described under "COBRA Terminating Events" in this section.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II. The contents of the notice must be such that the Plan Administrator is able to determine the covered Member and qualified

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beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

None of the notice requirements will be enforced if the Member or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

### *Trade Act of 2002*

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Member must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

## **COBRA Terminating Events**

COBRA continuation coverage under the Plan will end on the earliest of the following dates:

COBRA continuation coverage under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Member's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions: (i) notice of such disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first eighteen months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months; and (iii) if the Qualified Beneficiary entitled to the eleven

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months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Member, divorce or legal separation of the Member, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C., D., or E.).
- C. With respect to Qualified Beneficiaries, and to the extent that the Member was entitled to Medicare prior to the qualifying event:
  - i. Eighteen months from the date of the Member's Medicare entitlement; or
  - ii. Thirty-six months from the date of the Member's Medicare entitlement, if a second qualifying event (that was due to either the Member's termination of employment or the Member's work hours being reduced), occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the Member became entitled to Medicare subsequent to the qualifying event:
  - i. Thirty-six months from the date of the Member's termination of employment or work hours being reduced (first qualifying event), if:
    - a. the Member's Medicare entitlement occurs within the eighteen month continuation period; and

- b. if absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

- E. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.) and the retired Member dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Member's death.
- H. The date the entire Plan ends.
- I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

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## Uniformed Services Employment and Reemployment Rights Act

A Member who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Member and the Member's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified pursuant to continue coverage pursuant to the USERRA, Member may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Member's behalf. If a Member's Military Service is for a period of time less than 31 days, the Member may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Member may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Member's absence from work; or
- The day after the date on which the Member fails to apply for, or return to, a position of employment.

Regardless of whether an Member continues health coverage, if the Member returns to a position of employment, the Member's health

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coverage and that of the Member's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Member or the Member's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

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# Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Plan.

## Plan Document

This Plan Document presents an overview of your Benefits. In the event of any discrepancy between this Plan Document and any other document, the Plan Document shall govern.

## Relationship with Providers

The relationships between us, UnitedHealthcare, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or Members. Nor are they agents or Members of UnitedHealthcare. Neither we nor any of our Members are agents or Members of Network providers. Neither we nor UnitedHealthcare are liable for any act or omission of any provider.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

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UnitedHealthcare is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

The Plan Administrator 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 Benefits.
- Notifying you of the termination or modifications to the Plan.

## Your Relationship with Providers

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

- You are responsible for choosing your own provider.
- 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 us is that of employer and Member, Dependent or other classification as defined in the Plan.

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## Interpretation of Benefits

We and UnitedHealthcare have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this Plan Document and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

We and UnitedHealthcare may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

## Administrative Services

We may arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion.

## Amendments to the Plan

Any change or Amendment to or termination of the Plan, its Benefits or its terms and conditions, in whole or in part, shall be made solely by a majority vote of the Health Service System Board, as allowed by City Charter. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the Plan Document.

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## Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by Health Service System staff, the Health Service Board, UnitedHealthcare, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

## Information and Records

At times UnitedHealthcare may need additional information from you. You agree to furnish all information and proofs that may be reasonably required regarding any matters pertaining to the Plan. If you do not provide this information when requested, it may delay payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish UnitedHealthcare with all information or copies of records relating to the services provided to you. UnitedHealthcare will 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 Member's enrollment form. We and the UnitedHealthcare agree that such information and records will be considered confidential.

We and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, 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 Plan, we, UnitedHealthcare, and our related entities may use and transfer the

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information gathered under the Plan for research and analytic purposes.

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, we or UnitedHealthcare may designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

## 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 Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any

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legal theory of any type for the reasonable value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Plan Document, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, 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 a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Covered Persons agree as follows:

- That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan,
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,

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- responding to requests for information about any accident or injuries,
- appearing at depositions and in court, and
- obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.
- That regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by the Plan may also be considered to be benefits advanced.
- That Covered Persons agree that if they 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, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.
- That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, 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 institution of legal action against the Covered Person.
- That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.
- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.
- That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.
- That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.

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- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.
- That the Plan' rights will not be reduced due to the Covered Person's own negligence.
- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.
- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.
- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

## 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 either 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.

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- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. 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 that are payable under the Plan. 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 or UnitedHealthcare to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. If you want to bring a legal action against us or UnitedHealthcare, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or UnitedHealthcare.

You cannot bring any legal action against us or UnitedHealthcare for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or UnitedHealthcare you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against us or UnitedHealthcare.

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# Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Plan Document.
- Is not intended to describe Benefits.

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

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

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

**Amendment** - any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

**Annual Deductible** - the amount you must pay for Covered Health Services in a Plan Year before we will begin paying for Benefits in that Plan Year.

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**ART** - Assisted Reproductive Technology services for person who are clinically deemed to be high risk if pregnancy occurs, or who have not reasonable expectation of becoming pregnant.

**Autism Spectrum Disorders** – a group of neurobiological disorders that includes *Autistic Disorder, Rbett’s Syndrome, Asperger’s Disorder, Childhood Disintegrated Disorder, and a Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

**Benefits** - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this Plan Document and any applicable Riders and Amendments.

**Personal Health Support<sup>SM</sup>** - a program provided by UnitedHealthcare designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

**Claim Administrator**- UnitedHealthcare, or its affiliate, that provides certain claim administration services for the Plan.

**Coinsurance** - the charge you are required to pay for certain Covered Health Services. Coinsurance is a percentage of Eligible Expenses.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Personal Health Support<sup>SM</sup> on our behalf.

**Covered Health Service(s)** -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not

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Covered--Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Plan Document; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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

**Custodial Care** - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Dependent** - the Member's legal spouse or an unmarried Dependent child of the Member or the Member's spouse. All references to the

spouse of a Member 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 Member or the Member's spouse.

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

- A Dependent includes any unmarried Dependent child under 19 years of age.
- A Dependent includes an unmarried Dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be primarily Dependent upon the Member for support and maintenance and is declared as an exemption on the Members income tax return.

The Member 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. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

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**Designated United Resource Network Facility** - a Hospital that UnitedHealthcare names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with UnitedHealthcare to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within our geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

**Domestic Partner** - a person of the opposite or same sex with whom the Member has established a Domestic Partnership relationship.

**Domestic Partnership** - a relationship between a Member and one other person of the opposite or same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.

They must be financially interdependent. The Member and Domestic Partner must jointly sign the affidavit of Domestic Partnership, if required.

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

- Can withstand repeated use.

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- 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 in the home.

**Eligible Expenses** - the amount we will pay for Covered Health Services, incurred while the Plan is in effect, which are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from Non-Network providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at UnitedHealthcare's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area, or (2) applying the negotiated rates agreed to by the Non-Network provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- 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 UnitedHealthcare accepts.

**Eligible Person** - an Employee of the Plan Sponsor who is:

- a regular permanent Employee.
- a regular scheduled provisional Employee.
- "as needed" Employee who has worked 1,040 hours in any consecutive twelve month period, whose normal work week is not less than 20 hours.
- members of Boards or Commissions as allowed by the Admin Code.
- officer/Employee of the Board of Education.
- officer/Employee of San Francisco Community College District.
- officer/Employee of Transportation Authority, San Francisco Parking Authority, San Francisco Redevelopment Agency, or San Francisco Superior Court.

**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.

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**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 Plan.

**Experimental or Investigational Services** - medical, surgical, diagnostic, psychiatric, substance use or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination 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.
- 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.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

- 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.
- 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, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

**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.

**Intermediate Care** – Mental Health or Substance Use Disorder treatment that encompasses one the following:

- Care at a Residential Treatment Facility.
  - Care at a Partial Hospitalization/Day Treatment Program.
- Care through an Intensive Outpatient Treatment Program.

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

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

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

**Lifetime Maximum Plan Benefit** - the lifetime maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other Plan of the Plan Sponsor. When the Lifetime Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

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

**Member** - an Eligible Person who is properly enrolled under the Plan. The Member is the person (who is not a Dependent) on whose behalf the Plan is established.

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

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**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 Plan.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with UnitedHealthcare or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

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 Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

**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.

**PPO Network Benefits** - Benefits for Covered Health Services that are provided by a Network Physician or other Network provider.

**PPO Non-Network Benefits** - Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Network provider.

**Open Enrollment Period** - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

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**Out-of-Area Benefits** - Benefits for Covered Health Services that are provided to Members whose residence is NOT located in an area in which network providers are available.

**Out-of-Pocket Maximum** - the maximum amount you pay out-of-pocket every Plan Year after the Annual Deductible is met. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that Plan Year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Coinsurances for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify Personal Health Support<sup>SM</sup> as described in (Section 1: What's Covered-- Benefits) under the *Must You Notify Personal Health Support<sup>SM</sup>?* column.
- Charges that exceed Eligible Expenses.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

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- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Personal Health Support<sup>SM</sup> as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Personal Health Support<sup>SM</sup>?* column.
- Charges that exceed Eligible Expenses.
- Non-Emergency Health Services.

**Physician** - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 Plan.

**Plan** - City Health Plan PPO and Out of Area Plan for the City and County of San Francisco.

**Plan Administrator** - is the Health Service System of the City and County of San Francisco.

**Plan Sponsor** - City and County of San Francisco. References to "we", "us", and "our" throughout the Plan Document refer to the Plan Sponsor.

**Pregnancy** - includes all of the following:

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

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**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 Administrator.
- 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; and
  - 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 Plan Document. Riders are subject to all conditions, limitations and exclusions of the Plan 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.

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

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

**Spinal Treatment** - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Use 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.

**Transitional Care** – Mental Health Services/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, 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.

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supervised living arrangement 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 Services** - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- 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. (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.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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 and UnitedHealthcare may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the UnitedHealthcare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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**Urgent Care Center** - a facility, other than a Hospital, 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.

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# Riders, Amendments, Notices

**Outpatient Prescription Drug Rider**

**Attachment I**

**City Health Plan PPO and  
Out of Area Plan**

**for**

**City and County of San  
Francisco**

**Outpatient  
Prescription Drug  
Rider**

# Table of Contents

## Section 3: Glossary of Defined Terms ..... 89

### **Introduction..... 81**

Coverage Policies and Guidelines..... 81

Identification Card (ID Card) - Network Pharmacy..... 81

### **Section 1: What's Covered--Prescription**

#### **Drug Benefits ..... 82**

Benefits for Outpatient Prescription Drug Products ..... 82

When a Brand Name Drug Becomes Available as a Generic ..... 82

Supply Limits..... 82

Notification Requirements ..... 83

What You Must Pay..... 83

Payment Information ..... 84

Copayment..... 84

Infertility Prescription Drug Products..... 84

Smoking Cessation Products..... 84

Benefit Information..... 85

Prescription Drugs from a Retail Network Pharmacy ..... 85

Prescription Drugs from a Retail Non-Network Pharmacy..... 85

Prescription Drug Products from a Mail Service Network  
Pharmacy..... 86

### **Section 2: What's Not Covered--Exclusions ... 87**

*To continue reading, go to right column on this page.*

*To continue reading, go to left column on next page.*

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# Outpatient Prescription Drug Benefits

This Rider to the Plan Document provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at either a Network Pharmacy or a Non-Network Pharmacy.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Plan Document (Section 10: Glossary of Defined Terms).

**NOTE:** The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Plan Document does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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# Introduction

## Coverage Policies and Guidelines

UnitedHealthcare's Pharmacy and Therapeutics Committee is the national committee which reviews all drugs that are newly approved by the FDA. The Pharmacy and Therapeutics Committee evaluates the use of the newly approved prescription drug. The Pharmacy and Therapeutics Committee objectively evaluates drugs for therapeutic treatment and safety. The evaluation includes, but is not limited to: safety and efficacy; supply limits; notification requirements. The Pharmacy and Therapeutics Committee makes recommendations to UnitedHealthcare's Preferred Drug List Management Committee for final approval. This two-step process is designed to establish coverage policies and guidelines that promote quality and cost-effective drug therapy.

Even after a drug is included on the Prescription Drug List, this evaluation continues at least annually or as new information becomes available.

## 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 for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Plan Document (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 Cost (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.

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# Section 1: What's Covered-- Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network or non-Network Pharmacy.
- Refer to exclusions in your Plan Document (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

## Benefits for Outpatient Prescription Drug Products

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

## When a Brand Name Drug Becomes Available as a Generic

When a Prescription Drug Product becomes available as a Generic, the Brand-name version may no longer be available on the Prescription Drug List, and your Copayment may change.

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You will either pay the Generic Copayment, if you choose to receive the Generic drug, or you may pay the higher Copayment for a Brand-name Prescription Drug Product which is not on the Prescription Drug List, if you choose to continue receiving the Brand-name or if your Physician determines that you should continue receiving the Brand-name.

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by use, please review the definitions contained in *Section 3: Glossary of Defined Terms* at the end of this Rider. You should also check the current classification on the Prescription Drug List through the Internet at [www.myuhc.com](http://www.myuhc.com) or [www.365wellst.com](http://www.365wellst.com) or by calling the telephone number on your ID care.

## Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the *Benefit Information* table. For a single Copayment, 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 UnitedHealthcare has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may obtain a current list of Prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at [www.myuhc.com](http://www.myuhc.com) or [www.365wellst.com](http://www.365wellst.com) or by calling the telephone number on your ID card. The list is subject to periodic review and modification.

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## Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify UnitedHealthcare or its designee. The reason for notification is to determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

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

**Network Pharmacy Notification.** When certain Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

**Non-Network Pharmacy Notification.** When certain Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare as required.

The list of Prescription Drug Products requiring notification is subject to periodic review and modification. You may obtain a current list of Prescription Drug Products that require notification through the Internet at [www.myuhc.com](http://www.myuhc.com) or [www.365wellst.com](http://www.365wellst.com) or by calling the telephone number on your ID card.

If UnitedHealthcare is not notified 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. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement as described in the Plan Document (Section 5: How to File a Claim).

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When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (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.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed.

## What You Must Pay

You are responsible for paying the applicable Copayment described in the *Benefit Information* table when Prescription Drug Products are obtained from a retail or mail service Pharmacy.

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 Plan Document:

- Copayments for Prescription Drug Products.
- 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 the contracted rate (Prescription Drug Cost) will not be available to you.

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## Payment Information

Payment Term	Description	Amounts
<b>Copayment</b>	<p>Copayments for a Prescription Drug Product at a Network Pharmacy will be a specific dollar amount.</p> <p>Copayments for a Prescription Drug Product at a non-Network Pharmacy will be based on the actual retail cost of the prescription and may result in a higher out-of-pocket expense.</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment or</li> <li>• The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product.</li> </ul> <p>For Prescription Drug Products at a mail service Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment or</li> <li>• The Prescription Drug Cost for that Prescription Drug Product.</li> </ul> <p><i>See the Copayments stated in the Benefit Information table for amounts.</i></p>
<b>Infertility Prescription Drug Products</b>	Benefits for Prescription Drug Products for the treatment of infertility are covered.	Benefits for Prescription Drug Products for the treatment of infertility are covered at 50%.
<b>Smoking Cessation Products</b>	Benefits for smoking cessation products	Benefits for smoking cessation are covered at 50%. Over the counter drugs are not covered. The products are covered for a maximum of 180 days which equals two 90-day programs.

## Benefit Information

### Description of Pharmacy Type and Supply Limits

### Your Copayment Amount

#### Prescription Drugs from a Retail Network Pharmacy

Benefits for outpatient Prescription Drug Products dispensed by 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 an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.
- For Maintenance Medications, as written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product (for the payment of up to three Copayments), unless adjusted based on the drug manufacturer's packaging size. In order to receive the maximum Benefit, you should ask your provider to write your Prescription Order or Refill for the full 90 days.

\$5 per Prescription Order or Refill for a **Generic Prescription Drug Product**.

\$20 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on Tier 2 of the Prescription Drug List**.

\$35 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on Tier 3 of the Prescription Drug List**.

#### Prescription Drugs from a Retail Non-Network Pharmacy

Benefits for outpatient 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 Plan Document. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge (which includes dispensing fee and sales tax) for that Prescription Drug Product. All reimbursements

50% of the balance after a \$5 copayment per Prescription Order or Refill for a **Generic Prescription Drug Product**.

50% of the balance after a \$20 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on Tier 2 of the Prescription Drug List**.

50% of the balance after a \$35 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on Tier 3 of the Prescription Drug List**.

**Description of  
Pharmacy Type and Supply Limits**

**Your Copayment Amount**

are based on negotiated fees. 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.

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 an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.
- For Maintenance Medications, as written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product (for the payment of up to three Copayments), unless adjusted based on the drug manufacturer's packaging size. In order to receive the maximum Benefit, you should ask your provider to write your Prescription Order or Refill for the full 90 days.

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**Prescription Drug Products from a Mail Service  
Network Pharmacy**

Benefits for outpatient Prescription Drug Products dispensed by a mail service 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.

To receive the maximum Benefit, you should ask your provider to write your Prescription Order or Refill for the full 90 days.

**For up to a 90 day supply, your Copayment is:  
\$10 per Prescription Order or Refill for a **Generic  
Prescription Drug Product.****

**\$40 per Prescription Order or Refill for a **Brand-name  
Prescription Drug Product on Tier 2 of the  
Prescription Drug List.****

**\$70 per Prescription Order or Refill for a **Brand-name  
Prescription Drug Product on Tier 3 of the  
Prescription Drug List.****

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## Section 2: What's Not Covered-- Exclusions

Exclusions from coverage listed in the Plan Document apply also to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
2. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental or Investigational Service or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.
4. 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.
5. 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.

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6. Any product dispensed for the purpose of appetite suppression and other weight loss products except as covered with prior authorization.
7. A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by UnitedHealthcare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
8. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
9. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
10. Unit dose packaging of Prescription Drug Products.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
15. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in

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over-the-counter form or equivalent, except as required to treat symptoms related to viral infections causing the common cold.

16. New Prescription Drug Products and/or new dosage forms until the date they are reviewed by UnitedHealthcare's Pharmacy and Therapeutics Committee and approved by UnitedHealthcare's Prescription Drug List Management Committee.
17. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
18. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

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## Section 3:

# Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider.
- Is not intended to describe Benefits.

**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 UnitedHealthcare identifies as a Brand-name product. A Prescription Drug Product is classified as a Brand-name based on available data resources, such as 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 UnitedHealthcare.

**Generic** - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product. Classification of a Prescription Drug Product as a Generic is determined by UnitedHealthcare and not by the manufacturer or pharmacy. A Prescription Drug Product is classified as a Generic based on available data resources, such as 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 UnitedHealthcare.

**Maintenance Medications** - a list, as UnitedHealthcare designates, of Prescription Drug Products that are commonly prescribed by

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Physicians for long-term use. This list is subject to periodic review and modification. Contact UnitedHealthcare to obtain a copy of the list of Maintenance Medications.

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

A Network Pharmacy can be either a retail or a mail service 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 FDA, and ending on the earlier of the following dates:

- The date it is approved by UnitedHealthcare's Prescription Drug List 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 sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using the Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

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**Prescription Drug Cost** - the rate UnitedHealthcare has agreed to pay Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

**Prescription Drug List** - a list that identifies those Prescription Drug Products which are preferred by UnitedHealthcare for dispensing to Covered Persons when appropriate. This list is subject to periodic (at least quarterly) review and modification. Contact UnitedHealthcare at the telephone number on your ID card to obtain a copy of the current Prescription Drug List or you can access it through the Internet at [www.myuhc.com](http://www.myuhc.com) or [www.365wellst.com](http://www.365wellst.com).

**Prescription Drug Product** - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. 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 Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - insulin syringes with needles;
  - blood testing strips - glucose;
  - urine testing strips - glucose;
  - ketone testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
  - glucose monitors.

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**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.

**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.

**- End of Outpatient Prescription Drug Rider -**

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# Attachment

## I

### Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan 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 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.

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

Under Federal law, health insurance issuers 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 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, 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, an 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.

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