

Summary Plan Description

San Francisco Health Service System Active, Active Out-of-Area and Early Retirees (City Plan)

Effective: January 1, 2019
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TABLE OF CONTENTS

SECTION 1 - WELCOME 1

SECTION 2 - INTRODUCTION.....3

 Eligibility 3

 Cost of Coverage 3

 How to Enroll 4

 When Coverage Begins 4

 Changing Your Coverage..... 4

SECTION 3 - HOW THE PLAN WORKS.....6

 Claims Administrator 6

 Network and Non-Network Benefits 7

 Eligible Expenses..... 9

 Annual Deductible..... 10

 Coinsurance 10

 Out-of-Pocket Maximum 11

SECTION 4 - PERSONAL HEALTH SUPPORT13

SECTION 5 - PLAN HIGHLIGHTS 15

 Payment Terms and Features..... 15

 Schedule of Benefits..... 17

SECTION 6 - ADDITIONAL COVERAGE DETAILS25

 Acupuncture Services..... 25

 Ambulance Services - Emergency 26

 Cancer Resource Services (CRS) 26

 Clinical Trials – - Routine Patient Care Costs 27

 Congenital Heart Disease (CHD) Surgeries..... 28

 Dental Services - Accident Only..... 29

 Diabetes Services 31

 Durable Medical Equipment (DME)..... 32

 Emergency Health Services - Outpatient 34

 Gender Dysphoria Treatment..... 34

 Hearing Aids..... 36

Home Health Care.....	37
Hospice Care	38
Hospital - Inpatient Stay	38
Infertility Services and Fertility Solutions (FS) Program.....	39
Kidney Resource Services (KRS).....	40
Lab, X-Ray and Diagnostic - Outpatient.....	41
Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.....	42
Neurobiological Disorders - Autism Spectrum Disorder Services.....	43
Nutritional Counseling.....	44
Obesity Surgery	45
Ostomy Supplies	45
Pharmaceutical Products - Outpatient.....	45
Physician Fees for Surgical and Medical Services	46
Physician's Office Services - Sickness and Injury.....	46
Pregnancy - Maternity Services.....	47
Preventive Care Services.....	48
Prosthetic Devices	49
Reconstructive Procedures	49
Rehabilitation Services - Outpatient Therapy and Chiropractic/Manipulative Treatment	51
Scopic Procedures - Outpatient Diagnostic and Therapeutic.....	53
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	54
Substance-Related and Addictive Disorders Services.....	55
Surgery - Outpatient.....	56
Therapeutic Treatments - Outpatient.....	56
Transplantation Services	57
Travel and Lodging.....	58
Urgent Care Center Services	60
Weight Loss Services.....	61
SECTION 7 - CLINICAL PROGRAMS AND RESOURCES	62
Consumer Solutions and Self-Service Tools.....	62
Disease and Condition Management Services.....	66
Wellness Programs.....	68

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER..... 70

- Alternative Treatments..... 70
- Dental 70
- Devices, Appliances and Prosthetics 71
- Drugs 72
- Experimental or Investigational or Unproven Services 73
- Foot Care 73
- Gender Dysphoria 74
- Medical Supplies and Equipment 74
- Mental Health, Neurobiological Disorders - Autism Spectrum Disorders and Substance-Related and Addictive Disorders Services..... 75
- Nutrition..... 76
- Personal Care, Comfort or Convenience 76
- Physical Appearance..... 77
- Procedures and Treatments..... 78
- Providers 79
- Reproduction..... 80
- Transplants..... 80
- Services Provided under Another Plan..... 81
- Travel..... 81
- Types of Care 81
- Vision and Hearing..... 81
- All Other Exclusions 82

SECTION 9 - CLAIMS PROCEDURES 84

- Network Benefits 84
- Non-Network Benefits 84
- Prescription Drug Benefit Claims 84
- How To File Your Claim..... 84
- Health Statements..... 86
- Explanation of Benefits (EOB) 86
- Claim Denials and Appeals..... 87
- Limitation of Action..... 95

SECTION 10 - COORDINATION OF BENEFITS (COB) 96

Determining Which Plan is Primary 96

When This Plan is Secondary..... 98

When a Covered Person Qualifies for Medicare..... 98

Medicare Cross-Over Program..... 99

Right to Receive and Release Needed Information..... 100

Overpayment and Underpayment of Benefits..... 100

SECTION 11 - SUBROGATION AND REIMBURSEMENT 102

SECTION 12 - WHEN COVERAGE ENDS..... 107

 Medical Leave of Absence..... 108

 Coverage for a Disabled Child..... 108

 Continuing Coverage Through COBRA..... 108

 When COBRA Ends..... 112

 Uniformed Services Employment and Reemployment Rights Act..... 112

SECTION 13 - OTHER IMPORTANT INFORMATION 114

 Qualified Medical Child Support Orders (QMCSOs) 114

 Your Relationship with UnitedHealthcare and San Francisco Health Service System . 114

 Relationship with Providers 115

 Your Relationship with Providers 116

 Interpretation of Benefits 116

 Information and Records..... 116

 Incentives to Providers 117

 Incentives to You..... 118

 Rebates and Other Payments 118

 Workers' Compensation Not Affected..... 118

 Future of the Plan..... 118

 Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies..... 119

SECTION 14 - GLOSSARY 121

SECTION 15 - PRESCRIPTION DRUGS 137

 Prescription Drug Coverage Highlights 137

 Identification Card (ID Card) – Network Pharmacy..... 138

 Benefit Levels 139

 Retail 140

Mail Order..... 140

Designated Pharmacy..... 141

Assigning Prescription Drugs to the PDL..... 141

Notification Requirements 142

Prescription Drug Benefit Claims 144

Limitation on Selection of Pharmacies..... 144

Supply Limits..... 144

If a Brand-name Drug Becomes Available as a Generic..... 144

Prescription Drugs that are Chemically Equivalent..... 144

Special Programs..... 144

Coupons, Incentives and Other Communications 145

Exclusions - What the Prescription Drug Plan Will Not Cover..... 145

Glossary - Prescription Drugs..... 148

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION 151

ATTACHMENT I - HEALTH CARE REFORM NOTICES 152

 Patient Protection and Affordable Care Act ("PPACA")..... 152

ATTACHMENT II - NOTICES 153

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS 154

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS..... 156

ADDENDUM - UNITEDHEALTH ALLIES..... 163

 Introduction..... 163

 What is UnitedHealth Allies? 163

 Selecting a Discounted Product or Service 163

 Visiting Your Selected Health Care Professional..... 163

 Additional UnitedHealth Allies Information 164

ADDENDUM - PARENTSTEPS® 165

 Introduction..... 165

 What is ParentSteps? 165

 Registering for ParentSteps 165

 Selecting a Contracted Provider..... 166

 Visiting Your Selected Health Care Professional..... 166

 Obtaining a Discount..... 166

Speaking with a Nurse..... 166
Additional ParentSteps Information..... 166

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (866) 282-0125;
- Claims submittal address: UnitedHealthcare - Claims, P. O. Box 30555, Salt Lake City, UT 84130-0555; and
- Online assistance: <http://welcometouhc.com/sfhss>.

The San Francisco Health Service System (SFHSS) is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure guidelines of applicable laws. It supersedes any previous printed or electronic SPD for this Plan.

The San Francisco Health Service System intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The San Francisco Health Service System is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Choice Plus, Out-of-Area and Select Plus plans work. If you have questions call the number on the back of your ID card or contact the Health Service System.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.sfhss.org or request printed copies by contacting the San Francisco Health Service System at 1-800-541-2266.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- The San Francisco Health Service System (SFHSS) is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you meet the eligibility rules as defined in the San Francisco Health Service System (SFHSS) Rules which are available at www.sfhss.org/member_services/rules.html. An eligible Member may have eligible Dependents as defined in the HSS Rules, your child or your Spouse or Domestic Partner's child as defined by the SFHSS Eligibility Rules.

Coverage for a Dependent child acquired through birth will be automatically covered for a 31-day period under the Participants social security number as baby boy or baby girl. Claims incurred and submitted for Covered Health Services during this period of time will be paid by the Plan. Any claims received after the 31-day period, for dates of service after the 31 days post-birth, will be denied unless the Dependent child has already been added as a Dependent.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse or Domestic Partner are both covered under the Plan, you may each be enrolled as a Member or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

Cost of Coverage

You and the San Francisco Health Service System share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of the San Francisco Health Service System's cost in covering a Domestic Partner may be imputed to the Member as income. In addition, the share of the Member's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the San Francisco Health Service System reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting the San Francisco Health Service System (SFHSS) or logging onto www.sfhss.org.

How to Enroll

To enroll, contact the San Francisco Health Service System (SFHSS) within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the San Francisco Health Service System within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Coverage will become effective for Employees and Dependents at 12:01 a.m. Pacific Time on the eligibility date established by your Plan Administrator.

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, the Plan 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.

Changing Your Coverage

You may make coverage changes through your Plan Administrator during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). You can obtain more information on allowable status changes by contacting the San Francisco Health Service System (SFHSS) or logging onto www.sfhss.org.

If you wish to change your elections, you must contact the San Francisco Health Service System within 30 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Claims Administrator;
- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Claims Administrator

UnitedHealthcare is a private healthcare claims administrator. When the Plan uses the words "Claims Administrator" in this SPD, it is a reference to United HealthCare Services, Inc.

UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The San Francisco Health Service System is solely responsible for paying Benefits described in this SPD.

Requirements for Notifying the Claims Administrator

Network providers are generally responsible for notifying the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from Non-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator is not notified.

Services for which you are required to provide notification are identified in Section 6, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that notification timelines apply. Refer to the applicable Benefit description to determine how far in advance you must provide notification and any applicable reductions in Benefits.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

Contacting the Claims Administrator.

Simply call the toll-free number on your ID card.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or Non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a Non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to Non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a Non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Non-Network provider about their billed charges before you receive care. Emergency services received at a Non-Network Hospital are covered at the Network level.

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 rather than contracted provider rates which may result in higher out-of-pocket expenses.

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.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a Non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and they will work with you, your

Network Physician and Personal Health Support to coordinate care through a Non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a Non-Network provider.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain Non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 20 mile radius of your home zip code.

You can check a provider's Network status by visiting <http://welcometouhc.com/sfhss> or by calling UnitedHealthcare at the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Looking for a Network Provider?

In addition to other helpful information, <http://welcometouhc.com/sfhss>, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, <http://welcometouhc.com/sfhss> has the most current source of Network information. Use <http://welcometouhc.com/sfhss> to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto <http://welcometouhc.com/sfhss>.

Network providers are independent practitioners and are not employees of City and County of San Francisco or UnitedHealthcare.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. If you have a question about a Network provider's credentials or would like assistance in finding Network provider, please contact the Customer Service number on the back of your ID card.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the Non-Network level.

Eligible Expenses

The San Francisco's Health Service System (SFHSS) has delegated to the Claims Administrator the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a Non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the Non-Network Physician or Non-Network provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the Non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a Non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the Non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
 - ◆ When a rate is not published by CMS for the service, the Claims Administrator uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on

the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at <http://welcometouhc.com/sfhss> for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Foreign Claims

All foreign claims, emergency or non-emergency are to be paid without OptumInsight or medical claim review, EXCEPT large claims exceeding \$10,000. The Plan's Network Coinsurance and Deductible will apply.

Don't Forget Your ID Card

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and Non-Network Annual Deductibles for the Active and Early Retiree Plans.

The Annual Deductible amounts are shown in the first table in Section 5, *Plan Highlights*.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

The amounts the Plan pays for coinsurance for each benefit category are shown in the second table in Section 5, *Plan Highlights*.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 85% after you meet the Annual Deductible, you are responsible for paying the other 15%. This 15% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and Non-Network Out-of-Pocket Maximums for the Active and Early Retiree Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum amounts are shown in the first table in Section 5, *Plan Highlights*.

For the Active and Early Retiree Plan, Eligible Expenses charged by both Network and Non-Network providers apply toward both the Network individual Out-of-Pocket Maximum and the Non-Network individual Out-of-Pocket Maximum except as noted in the chart below. For Out-of-Area Plan members, covered out-of-pocket expenses apply toward the individual Out-of-Pocket Maximum except as noted in the chart below.

The following table identifies what does and does not apply toward your Network and Non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Pharmacy Copays described in Section 15, <i>Prescription Drugs</i>	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance payments for non-Emergency Health Services received in the Emergency room	No	No
All other Coinsurance payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying the Claims Administrator	No	No
Charges that exceed Eligible Expenses	No	No

How the Plan Works – Example

The following example illustrates how Annual Deductibles, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician versus a Non-Network Physician.

Network Benefits	Non-Network Benefits										
1. Gary goes to see a Network Physician, and presents his ID card.	1. Gary goes to see a Non-Network Physician, and presents his ID card.										
2. He receives treatment from the Physician. The Plan's Eligible Expense for the Network office visit equals \$125.	2. He receives treatment from the Physician. The Eligible Expense for his visit is \$175; however the Physician's fee is \$225.										
3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*	3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*										
4. Since Network Physician office visits are covered at 85%, Gary must pay \$19 (15% of the \$125 Eligible Expense). This amount is applied to his Out-of-Pocket Maximum.	4. Since Non-Network Physician office visits are covered at 50%, Gary must pay \$87.50 (50% of the \$175 Eligible Expense). This amount is applied to his Out-of-Pocket Maximum.										
5. The Plan pays \$106 (85% of the \$125 Eligible Expense).	5. The Plan pays \$87.50 (50% of the \$175 Eligible Expense).										
	6. The Physician's office, at its discretion, might bill Gary for the remaining \$50:										
	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">\$225</td> <td style="text-align: center;">-</td> <td style="text-align: center;">\$175</td> <td style="text-align: center;">=</td> <td style="text-align: center;">\$50</td> </tr> <tr> <td style="text-align: center;">(Physician's fee)</td> <td></td> <td style="text-align: center;">(Eligible Expense)</td> <td></td> <td></td> </tr> </table>	\$225	-	\$175	=	\$50	(Physician's fee)		(Eligible Expense)		
\$225	-	\$175	=	\$50							
(Physician's fee)		(Eligible Expense)									
	Gary's \$50 payment does not apply to his Out-of-Pocket Maximum.										

*Although Non-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases.

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified by the Claims Administrator when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss

and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network or Out-of-Area	Non-Network
<p>Annual Deductible¹</p> <ul style="list-style-type: none"> ■ Individual ■ Individual plus one Dependent ■ Individual plus two or more Dependents (not to exceed the applicable Individual amount per Covered Person). 	<p>\$250</p> <p>\$500</p> <p>\$750</p>	<p>\$500</p> <p>\$1,000</p> <p>\$1,500</p>
<p>Annual Out-of-Pocket Maximum^{1,2}</p> <ul style="list-style-type: none"> ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person). 	<p>\$3,750</p> <p>\$12,700</p>	<p>\$7,500</p> <p>Not Applicable</p>
<p>Lifetime Maximum Benefit³</p> <p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p>	<p>Unlimited</p>	

¹The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

²The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

³Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

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

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
Acupuncture Services Up to \$1,000 per calendar year	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Ambulance Services - Emergency	85% after you meet the Annual Deductible	85% after you meet the Annual Deductible
Cancer Resource Services (CRS) <ul style="list-style-type: none"> ■ Hospital Inpatient Stay 	85% after you meet the Annual Deductible	Non-Network Benefits are not available.
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section; some exclusions may apply.	
Congenital Heart Disease (CHD) Surgeries <ul style="list-style-type: none"> ■ Hospital Inpatient Stay 	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Dental Services - Accident Only	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Diabetes Services <ul style="list-style-type: none"> ■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care 	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
<ul style="list-style-type: none"> ■ Diabetes Self-Management Items 	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> in this section and in Section 5, <i>Prescription Drugs</i> .	
Durable Medical Equipment (DME)	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Emergency Health Services - Outpatient <ul style="list-style-type: none"> ■ True Emergency ■ Non-Emergency <p>*Does not apply to the Out-of-Pocket Maximum</p>	85% after you meet the Annual Deductible	50%* after you meet the Annual Deductible
Gender Dysphoria See Section 6, <i>Additional Coverage Details</i> , for limits	Depending upon where the Covered Health Service is provided, Benefits for Gender Dysphoria Disorder treatment will be paid the same as those stated under each Covered Health Service category in this section and in Section 15, <i>Prescription Drugs</i> .	
Hearing Aids Up to \$2,500 per hearing impaired ear every 36 months	<i>Devices</i> 85% after you meet the Annual Deductible <i>Fitting and Testing</i> 85% after you meet the Annual Deductible	<i>Devices</i> 50% after you meet the Annual Deductible <i>Fitting and Testing</i> 50% after you meet the Annual Deductible
Home Health Care Up to 120 visits per calendar year	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospice Care Includes five days of respite care per lifetime	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
Hospital - Inpatient Stay	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Infertility Services and Fertility Solutions (FS) Program <ul style="list-style-type: none"> ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Outpatient services received at a Hospital or Alternate Facility <p>See Section 6, <i>Additional Coverage Details</i>, for limits. Diagnosis and treatment of underlying medical condition covered same as any other illness.</p>	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible 50% after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible 50% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	85% after you meet the Annual Deductible	Non-Network Benefits are not available.
Lab, X-Ray and Diagnostics - Outpatient	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
Mental Health Services <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient 	<p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
Neurobiological Disorders - Autism Spectrum Disorder Services <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient 	<p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
Nutritional Counseling <ul style="list-style-type: none"> ■ See Section 6, Additional Coverage Details. 	<p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p>
Obesity Surgery <ul style="list-style-type: none"> ■ Physician's Office Services ■ Physician Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay ■ Lab and x-ray <p>See Section 6, <i>Additional Coverage Details</i> for</p>	<p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
limits		
Ostomy Supplies	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pregnancy - Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.	
<ul style="list-style-type: none"> ■ Physician's Office Services ■ Midwife Covered for Hospital, or home birth. ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services 	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
<p>Preventive Care Services</p> <ul style="list-style-type: none"> ■ Physician Office Services ■ Well child exam ■ Well adult exam ■ Preventive immunizations ■ Lab, X-ray or Other Preventive Tests ■ Routine Mammography ■ Routine Scopic – Outpatient ■ Breast Pumps <p>Preventive Services are covered in-Network at 100%--no Copay, no Deductible, no limits.</p>	<p>100% Annual Deductible does not apply</p> <p>100% Annual Deductible does not apply</p> <p>100% Annual Deductible does not apply</p> <p>100% Annual Deductible does not apply</p> <p>100% Annual Deductible does not apply</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% Annual Deductible does not apply</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
Prosthetic Devices	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
<p>Reconstructive Procedures</p> <ul style="list-style-type: none"> ■ Physician's Office Services ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services 	<p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
<ul style="list-style-type: none"> ■ Prosthetic Devices ■ Surgery - Outpatient 	<p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
<p>Rehabilitation Services - Outpatient Therapy and Chiropractic/ Manipulative Treatment</p> <p>See Section 6, <i>Additional Coverage Details</i>, for visit limits</p>	<p><i>Chiropractic/ Manipulative Treatment</i> 50% after you meet the Annual Deductible</p> <p><i>All Other Therapies</i> 85% after you meet the Annual Deductible</p>	<p><i>Chiropractic/ Manipulative Treatment</i> 50% after you meet the Annual Deductible</p> <p><i>All Other Therapies</i> 50% after you meet the Annual Deductible</p>
<p>Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>	<p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p>
<p>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year.</p>	<p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p>
<p>Substance-Related and Addictive Disorders Services</p> <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient 	<p>85% after you meet the Annual Deductible</p> <p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p> <p>50% after you meet the Annual Deductible</p>
<p>Surgery - Outpatient</p>	<p>85% after you meet the Annual Deductible</p>	<p>50% after you meet the Annual Deductible</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network or Out-of Area	Non-Network
Therapeutic Treatments - Outpatient	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Provider)	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	
Travel and Lodging (If services rendered by a Designated Provider)	For patient and (companion of Dependent minor child patient) undergoing transplant procedures	
Urgent Care Center Services	85% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to http://welcometouhc.com/sfhss or by calling the telephone number on your ID card.	85% after you meet the Annual Deductible	Non-Network Benefits are not available.
Weight Loss Services Up to \$1,000 per lifetime	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

¹You must notify the Claims Administrator, as described in Section 3, *How The Plan Works* to receive full Benefits before receiving certain Covered Health Services from a Non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying the Claims Administrator before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Provider. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.*

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify the Claims Administrator before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

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

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

Any combination of Network Benefits and Non-Network Benefits is limited to \$1,000 per calendar year. All services rendered by an Acupuncturist count toward this maximum, including, but not limited to, physical therapy, ultraviolet therapy, massage therapy, hot and cold packs, office visits, and electric stimulation therapy.

Did you know...

You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services - Emergency

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials – - Routine Patient Care Costs

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain *Category B* devices;
 - certain promising interventions for patients with terminal illnesses; and
 - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- services other than healthcare services, such as travel, housing, companion expenses, and other non-clinical expenses;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

Please remember that you must notify the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a Designated Provider participating in the Congenital Heart Disease Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;

- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnosis. Contact the Claims Administrator at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Please remember, Covered Health Services required to be received by a Designated Provider, you must notify the Claims Administrator as soon as the possibility of a CHD surgery arises. If you do not notify the Claims Administrator and if, as a result, the CHD surgeries are not performed by a Designated Provider, Benefits for Covered Health Services will be subject to a \$400 reduction.

Dental Services - Accident Only

Dental services are covered by the Plan when any of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;

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

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth, or
- 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.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system);
- direct treatment of acute traumatic Injury, cancer or cleft palate;
- tumor of the gums.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;

- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify the Claims Administrator 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, the Claims Administrator can determine whether the service is a Covered Health Service. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits for Covered Health Services will be subject to a \$400 reduction.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	<p>Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.</p> <p>Benefits also include diabetic educational services for Covered Persons enrolled in a diabetic day care self-management education program. A Physician who is board-certified in internal medicine, endocrinology or pediatrics must oversee the program. Covered Health Services include the cost of the program and services given by a Physician or professional trained in diabetic treatment (such as a nurse, registered pharmacist or registered dietician) provided that their services do not duplicate those offered by the education program.</p> <p>Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.</p>
Diabetic Self-Management Items	<p>Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under <i>Durable Medical Equipment (DME)</i>, Orthotics and Supplies. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in</p>

Covered Diabetes Services	
	Section 15, <i>Prescription Drugs</i> .

Please remember for Non-Network Benefits, you must notify the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than \$1,000. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.

See *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient* in this section;

- custom shoe or foot orthotics and shoe inserts when determined by your Physician to be medically necessary;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Note: DME is different from prosthetic devices – see Prosthetic Devices in this section.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits for custom shoe or foot orthotics and shoe inserts are limited to one pair per calendar year. Benefits for shoe inserts are limited to three pairs per calendar year.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Please remember for Non-Network Benefits, you must notify the Claims Administrator if the retail purchase cost or cumulative rental cost of a single item will exceed \$1,000. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Please remember for Non-Network Benefits for custom shoe or foot orthotics you must notify the Claims Administrator if the retail purchase cost of a single item will exceed \$500. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a Non-Network Hospital as long as the Claims Administrator is notified within two business days of the admission after you are admitted to a Non-Network Hospital. If you continue your stay in a Non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Please remember for Non-Network Benefits, you must notify the Claims Administrator within two business days of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits for the Inpatient Hospital Stay will be subject to a \$400 reduction.

Gender Dysphoria Treatment

Benefits for the treatment of Gender Dysphoria limited to the following services:

- **psychotherapy** for gender identity disorders/dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section;
- **Cross-sex hormone therapy:**
 - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in this section.
 - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under Section 15, *Prescription Drugs*.
- **Puberty suppressing medication** injected or implanted by a medical provider in a clinical setting.
- laboratory testing to monitor the safety of continuous hormone therapy.
- **Surgery** for the treatment for Gender Dysphoria, including the surgeries listed below:

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva).

The following Procedures for the treatment of Gender Dysphoria may also be covered if medically necessary:

- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must be 18 years or older.

- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must 18 years or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
 - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
 - The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

The Claims Administrator has specific guidelines regarding Benefits for treatment of Gender Dysphoria. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Surgical Treatment: Please remember, for Non-Network Benefits you must notify the Claims Administrator as soon as the possibility for any of surgery arises. Please call the phone number that appears on your ID card. Benefits will be subject to a \$400 reduction.

Non-Surgical Treatment: Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this section.

Hearing Aids

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

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

Benefits are provided for fittings and replacement hearing aids when required due to damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's hearing occurs.

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

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

Any combination of Network Benefits and Non-Network Benefits is limited to \$2,500 per Covered Person per hearing impaired ear every 36 months. Hearing aids, fittings and replacement hearing aids are covered.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support will decide if Skilled Care is needed 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.

Any combination of Network Benefits and Non-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Please remember for Non-Network Benefits, that you must notify the Claims Administrator five business days before receiving services including nutritional foods as soon as reasonably possible. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits include five days of respite care during the entire period you are covered under the Plan.

Please remember for Non-Network Benefits, you must notify the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as follows:

- For scheduled admissions: five business days before admission or as soon as reasonably possible.
- For non-scheduled admissions (including Emergency admissions): as soon as is reasonably possible.

For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Infertility Services and Fertility Solutions (FS) Program

Therapeutic services for the treatment of infertility when provided by or under the direction of a Physician. The Plan pays Benefits for infertility when provided by Designated Providers participating in the *Fertility Solutions (FS)* program. Designated Provider is defined in Section 14, *Glossary*.

Note. Diagnostic services Benefits are covered as described under *Physician's Office Services - Sickness and Injury* in this section.

The Plan pays Benefits for the treatment of infertility for:

- Diagnosis and treatment of an underlying medical condition which causes infertility;
- Ovulation induction and controlled ovarian stimulation;
- Insemination procedures (Artificial Insemination (AI) and Intrauterine Insemination (IUI));
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm;
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only;
- Pre-implantation Genetic Screening (PGS) when used in conjunction with elective single embryo transfer. These technologies include, but are not limited to, array comparative genomic hybridization, quantitative polymerase chain reaction and single nucleotide polymorphism array testing;

Any combination of Network Benefits and Non-Network Benefits for infertility services is limited to six natural (intra-cervical) artificial inseminations, and/or three stimulated (intra-uterine) artificial inseminations, and/or two courses of gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or in vitro fertilization (IVF) per Covered Person during the entire period you are covered under the Plan.

For Cryopreservation and Fertility Preservation of sperm/oocytes/embryos when retrieved from a Covered Person. Benefits are for 12 continuous months (1 year) of storage per Covered Person for the entire period you are covered under the Plan. Benefits for retrieval of sperm/oocytes/embryos must be associated with a GIFT/IVF/ZIFT procedure.

Benefits for the diagnosis and treatment of an underlying medical condition which causes infertility is covered the same as any other illness.

Fertility Solutions (FS) Program

The Benefits described under Infertility in this section are provided under the Fertility Solutions (FS) program, as defined in Section 14, *Glossary*. Fertility Solutions (FS) provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

You will have access to a certain Network of FS Designated Facilities and Physicians participating in the Fertility Solutions program for infertility services. To enroll in the program and obtain information concerning infertility treatment, please contact Fertility Solutions at 1-866-774-4626.

What is Coinsurance?

Coinsurance is the amount you pay for a Covered Health Service, not including the Deductible.

For example, if the Plan pays 85% of Eligible Expenses for care received from a Network provider, your Coinsurance is 15%.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;

- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography.
- Sleep Studies
- Benefits include:
 - The facility charge and the charge for supplies and equipment.
 - Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
 - Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
 - Presumptive Drug Tests and Definitive Drug Tests.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

For Non-Network Benefits for sleep studies, you must notify the Claims Administrator five business days before scheduled services are received. . For Network Benefits, the Provider is responsible for notification. If you fail to notify the Claims Administrator, Benefits will be subject to a \$400 reduction

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

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator five business days before receiving an MRI or MRA. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.

- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Mental Health/Substance-Related and Addictive Disorders Administrator to receive these Benefits. For a scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide notification five business days in advance of the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For Network Benefits, the Provider is responsible for notification. Please call the number that appears on your ID card. Without notification, Benefits will be subject to a \$400 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental 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 for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Mental Health/Substance-Related and Addictive Disorders Administrator to receive these Benefits. For a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For Network Benefits, the Provider is responsible for notification. Please call the number that appears on your ID card. Without advance notification, Benefits will be subject to a \$400 reduction.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician’s office by an appropriately licensed or healthcare professional.

Benefits are limited to four visits per calendar year. This visit limit applies to Network Benefits and Non-Network Benefits combined.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Network Benefits for obesity surgery are limited to \$60,000 during the entire period you are covered under the Plan. Non-Network Benefits for obesity surgery are limited to \$10,000 during the entire period you are covered under the Plan.

Services that are not covered include weight loss programs, health club memberships and special foods.

Please remember for Non-Network Benefits, you must notify the Claims Administrator six months prior to surgery. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on the place of service where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at <http://welcometouhc.com/sfhss> or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at <http://welcometouhc.com/sfhss> or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by a Physician.

Benefits for preventive services are described under *Preventive Care Services* in this section.

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

Please remember for Non-Network Benefits you must notify the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA is performed. For Network Benefits, the Provider is responsible for notification. If notification is not provided as required, Benefits will be subject to a \$400 reduction.

Pregnancy - Maternity Services

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 in an inpatient facility or in the Covered Person's home, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

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

Please remember for Non-Network Benefits, you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits for the extended stay will be subject to a \$400 reduction.

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

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

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

You can find the list of preventive services that have a rating of "A" or "B" from the USPSTF by visiting <http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm>.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing;
- tests to support cardiovascular health; and
- IUD device and services, diaphragm fitting.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirements include the cost of renting or purchasing up to two pumps per year in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm; and

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

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

For Non-Network Benefits you must notify the Claims Administrator before obtaining prosthetic devices that exceed \$500 in cost per device. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Note: Prosthetic devices are different from DME – see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means 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.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required 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 other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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

Breast Reduction Procedures

Breast Reduction Surgery is a covered health service with documentation of all the following functional impairments:

- there is documented shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts;
- there is documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia; and
- the surgery is determined not to be cosmetic by Personal Health Support.

Note: Breast Reduction Surgery is NOT a covered health service when performed to improve appearance or for the purpose of improving athletic performance. Breast Reduction Surgery is covered when a reconstruction has been performed on the other breast (as part of the federal mandate).

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. For Network Benefits, the Provider is responsible for notification. When you provide notification, the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Rehabilitation Services - Outpatient Therapy and Chiropractic/Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- physical therapy;
- occupational therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.
- Chiropractic/Manipulative Treatment (including massage therapy);

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

Benefits are limited to:

- 60 visits per calendar year for physical, cognitive and occupational therapy combined;
- 60 visits per calendar year for speech therapy;
- 30 visits per calendar year for post-cochlear implant aural therapy;
- 20 visits per calendar year for pulmonary rehabilitation;
- 36 visits per calendar year for cardiac rehabilitation; and
- \$1,000 per calendar year for Chiropractic/Manipulative Treatment. Spinal manipulation by any provider type counts toward this maximum.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available 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.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care of Domiciliary Care. Even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as follows:

- For a scheduled admission: five business days before admission.
- For a non-scheduled admission as soon as is reasonably possible.

For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Transitional Living services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Mental Health/Substance-Related and Addictive Disorders Administrator to receive these Benefits. For a scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For Network Benefits, the Provider is responsible for notification. Please call the number that appears on your ID card. Without advance notification, Benefits will be subject to a \$400 reduction.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

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

For Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries, cochlear implant you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. For Network Benefits, the Provider is responsible for notification. If the Claims Administrator is not notified, Benefits will be subject to a \$400 reduction.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis

and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

Please remember for Non-Network Benefits, you must notify the Claims Administrator for the following outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. Services that require notification: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound. For Network Benefits, the Provider is responsible for Notification. If the Claims Administrator is not notified, as required, Benefits will be subject to a \$400 reduction.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. . Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider and received at a Designated Provider. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal;
- bone marrow (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 definition of a Covered Health Service; and
- CAR-T cell therapy for malignancies.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator of a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

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

The Plan has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Please remember for Network Benefits you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator is not notified and if, as a result, the services are not performed by a Designated Provider, Network Benefits will not be paid and you will be responsible for paying all charges.

Travel and Lodging

Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

Lodging

- A per diem rate, up to \$50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to \$100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.

- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

A maximum Benefit of \$10,000 per transplant per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures when UHC is primary and services are conducted at a Designated Provider. This is a per transplant benefit.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <http://welcometouhc.com/sfhss> or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Weight Loss Services

Any combination of Network and Non-Network Benefits for weight loss services when the program is provided by or under the direct supervision of a Physician.

Any combination of Network and Non-Network Benefits is limited to \$1,000 per Covered Person during the entire period you are covered under the Plan.

Please remember that you must notify the Claims Administrator five business days before receiving weight loss services. If you fail to notify the Claims Administrator, Benefits will be subject to a \$400 reduction.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

The San Francisco Health Service System (SFHSS) believes in giving you the tools you need to be an educated health care consumer. To that end, SFHSS has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the San Francisco Health Service System are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You and your Spouse are invited to learn more about your health and wellness at <http://welcometouhc.com/sfhss> and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to <http://welcometouhc.com/sfhss>. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – The San Francisco Health Service System's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the San Francisco Health Service System has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

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

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log onto <http://welcometouhc.com/sfhss> and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto <http://welcometouhc.com/sfhss>.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 51 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer; and
- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto <http://welcometouhc.com/sfhss> or call the toll-free number on your ID card.

<http://welcometouhc.com/sfhss>

UnitedHealthcare's member website, <http://welcometouhc.com/sfhss>, provides information at your fingertips anywhere and anytime you have access to the Internet. <http://welcometouhc.com/sfhss> opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With <http://welcometouhc.com/sfhss> you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;

- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on <http://welcometouhc.com/sfhss>

If you have not already registered as a <http://welcometouhc.com/sfhss> subscriber, simply go to <http://welcometouhc.com/sfhss> and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit <http://welcometouhc.com/sfhss> and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to <http://welcometouhc.com/sfhss> and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - education about the specific disease and condition,
 - medication management and compliance,
 - reinforcement of on-line behavior modification program goals,
 - preparation and support for upcoming Physician visits,
 - review of psychosocial services and community resources,
 - caregiver status and in-home safety,
 - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealthNotesSM

UnitedHealthcare provides a service called HealthNotes to help educate members and make suggestions regarding your medical care. HealthNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealthNotes report may include health tips and other wellness information.

UnitedHealthcare 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 as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealthNotes 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.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. To find out if you are eligible to participate in this program, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit www.realappeal.com.

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy, except as described under *Rehabilitation Services - Outpatient Therapy and Chiropractic/Manipulative Treatment* in Section 6, *Additional Coverage Details*;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic/Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

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

- extractions (including wisdom teeth);
- restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes;

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);
5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*;

Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter.

3. cranial banding;

4. the following items are excluded, even if prescribed by a Physician:
 - blood pressure cuff/monitor;
 - enuresis alarm;
 - non-wearable external defibrillator;
 - trusses;
 - ultrasonic nebulizers;
5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;
6. the replacement of lost or stolen prosthetic devices;
7. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; and
8. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
4. non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office;
5. over the counter drugs and treatments;
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. a Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year
8. a Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;
9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
10. a Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year; and
11. certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under

Diabetes Services in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

- cleaning and soaking the feet;
- applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

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

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. arch supports;

6. lifts and wedges; and

7. shoes (standard or custom), or shoe orthotics, except as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Calf implants.
- Skin resurfacing.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:

- compression stockings, ace bandages, diabetic strips, and syringes; and
- urinary catheters.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
 - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;
 3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;
 4. the replacement of lost or stolen Durable Medical Equipment; and
 5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorders and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorder - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments or a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.
8. Transitional Living services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
2. food of any kind. Foods that are not covered include:
 - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
 - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
 - oral vitamins and minerals;
 - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
 - other dietary and electrolyte supplements; and
3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;
4. guest service;
5. supplies, equipment and similar incidentals for personal comfort. Examples include:
 - air conditioners;
 - air purifiers and filters;
 - batteries and battery chargers;
 - dehumidifiers and humidifiers;
 - ergonomically correct chairs;
 - non-Hospital beds, comfort beds, motorized beds and mattresses;

- breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- electric scooters;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:
 - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
 - pharmacological regimens;
 - nutritional procedures or treatments;
 - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - hair removal or replacement by any means;
 - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
 - treatment for spider veins;
 - skin abrasion procedures performed as a treatment for acne;
 - treatments for hair loss;
 - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
 - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.

This exclusion does not apply to injectable Poly-L-lactic acid (Sculptra™) for Covered Persons with a medical diagnosis (e.g., temporal lobe wasting);
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs, even if for morbid obesity, except for programs provided by or under the direct supervision of a Physician;
4. wigs regardless of the reason for the hair loss; and
5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;
2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
3. rehabilitation services and Chiropractic/Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;
4. speech therapy to treat stuttering, stammering, or other articulation disorders;
5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Chiropractic/Manipulative Treatment* in Section 6, *Additional Coverage Details*;
6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);
8. psychosurgery (lobotomy);
9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;
10. chelation therapy, except to treat heavy metal poisoning;
11. Chiropractic/Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
13. non-surgical treatment for obesity, except as shown under *Weight Loss Services* in Section 6, *Additional Coverage Details*;
14. medical and surgical treatment of hyperhidrosis (excessive sweating);
15. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;
16. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors or cancer or obstructive sleep apnea; and
17. breast reduction surgery that is determined to be a Cosmetic Procedure.

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

- prior to ordering the service; or
- after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. the following infertility treatment-related services:
 - long-term storage, greater than 12 months, of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
 - donor services and all costs associated with oocyte or sperm donation (e.g., donor agency fees).
 - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
 - All costs associated with surrogate motherhood; all costs associated with a gestational carrier.
 - Ovulation predictor kits.
2. in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility;
3. surrogate parenting, donor oocytes (eggs), donor sperm and host uterus;
4. the reversal of voluntary sterilization;
5. oral contraceptives which are covered on the Prescription Drug plan;
6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
7. services provided by a doula (labor aide); and
8. parenting, pre-natal or birthing classes.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);
3. transplants that are not performed at a Designated Provider (this exclusion does not apply to cornea transplants); and
4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Travel

1. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 14, *Glossary*;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
3. purchase cost and associated fitting charges for eyeglasses or contact lenses;
4. frames and lenses after cataract surgery;
5. bone anchored hearing aids except when either of the following applies:
 - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
 - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions; and

6. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
 - missed appointments;
 - room or facility reservations;
 - completion of claim forms; or
 - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes;
4. diagnostic tests that are:
 - delivered in other than a Physician's office or health care facility; and
 - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
5. expenses for health services and supplies:
 - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;

This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;

- that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
 - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
 - 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 this Benefit Plan;
 - that exceed Eligible Expenses or any specified limitation in this SPD;
 - for which a Non-Network provider waives the Annual Deductible or Coinsurance amounts;
6. foreign language and sign language services;
 7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
 8. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

9. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
 - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
 - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
 - related to judicial or administrative proceedings or orders; or
 - required to obtain or maintain a license of any type; and
10. weight loss programs, health club memberships and special foods, except as stated in Section 6, *Additional Coverage Details*.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and Non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

How To File Your Claim

You can obtain a claim form by visiting <http://welcometouhc.com/sfhss>, calling the toll-free number on your ID card or contacting the Health Service Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Member;

- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;
 - the date the Sickness or Injury began; and
 - 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 and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a Non-Network provider with UnitedHealthcare's consent, and the Non-Network provider submits a claim for payment, you and the Non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the Non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare's may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a Non-Network provider is made, UnitedHealthcare on behalf of San Francisco Health Service System reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes San Francisco Health Service System (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to Refund of Overpayments in Section 10, Coordination of Benefits.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the Non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at <http://welcometouhc.com/sfhss>. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

UnitedHealthcare will send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can also view and print all of your EOBs online at <http://welcometouhc.com/sfhss>. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the San Francisco Health Service System. This 12-month requirement 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.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the San Francisco Health Service System within 60 days from receipt of the first level appeal determination. This request needs to come from you directly, and should not be requested on your behalf, by your provider. The San Francisco Health Service System must notify you of the appeal determination within 30 days after receiving the completed appeal for a pre-service denial and 60 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The San Francisco Health Service System will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the San Francisco Health Service System, or if the San Francisco Health Service System fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the San Francisco Health Service System's determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received the San Francisco Health Service System's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making the San Francisco Health Service System's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by the San Francisco Health Service System; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the San Francisco Health Service System. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the San Francisco Health Service System determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the San Francisco Health Service System. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	15 days
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
San Francisco Health Service System must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
San Francisco Health Service System must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

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 request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

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 request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the San Francisco Health Service System or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the San Francisco Health Service System or the Claims Administrator, 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 the San Francisco Health Service System or the Claims Administrator.

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

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to <http://welcometouhc.com/sfhss> or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;

- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first. Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Member under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that **meets the definition of a Covered Health Service under this Plan.**

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a Non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a Non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a Non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare*.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- individuals with end-stage renal disease, for a limited period of time; and
- disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible and Coinsurance requirements of the Plan.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated cross-over took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This cross-over process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Plan reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for 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 the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or

- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement. References to “you” or “your” in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor in a workers' compensation case or other matter alleging liability;
- any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or

otherwise), workers' compensation coverage, other insurance carriers or third party administrators;

- any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party;
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - 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;
 - responding to requests for information about any accident or injuries;
 - making court appearances;
 - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
 - complying with the terms of this section.
 - Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that

assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, personal injury protection Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights

and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end; and
- How to continue coverage after it 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, the San Francisco Health Service System will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date UnitedHealthcare receives written notice from the San Francisco Health Service System to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

You may also request to end your coverage under the Plan during annual Open Enrollment.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date UnitedHealthcare receives written notice from the San Francisco Health Service System to end your coverage, or the date requested in the notice, if later;
- the last day of the Member's pay period in which your Dependent child no longer qualifies as a Dependent under this Plan due to the attainment of age limits; or
- the date your Dependents no longer qualify as Dependents under this Plan for reasons other than age.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and the San Francisco Health Service System find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the San Francisco Health Service System has the right to demand that you pay back all Benefits the San Francisco Health Service System paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Medical Leave of Absence

If you are on a leave of absence from your job for medical reasons, Benefits under the Plan will continue.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as the child meets the eligibility rules as defined in the San Francisco Health Service System (SFHSS) Rules which are available at sfhss.org/member_services/rules.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if the San Francisco Health Service System is subject to the provisions of COBRA.

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 were 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; or

- a Member's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
San Francisco Health Service System files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the 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 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 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 11 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.

²This is a qualifying event for any Retired employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)

was filed.

³From the date of the Member's death if the Member dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Member and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail 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 you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Health Service Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

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.

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.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: 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 in this section, whichever is earlier.

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 to continue coverage pursuant to the USERRA, Members 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 a Member continues health coverage, if the Member returns to a position of employment, the Member's health 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.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and San Francisco Health Service System;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan;
- Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and San Francisco Health Service System

In order to make choices about your health care coverage and treatment, the San Francisco Health Service System believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- San Francisco Health Service System and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

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

Relationship with Providers

The relationships between the San Francisco Health Service System, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City and County of San Francisco's agents or employees, nor are they agents or employees of UnitedHealthcare. City and County of San Francisco and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

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

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

The San Francisco Health Service System is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of the service fee to UnitedHealthcare;
- the funding of Benefits on a timely basis; and 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;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- 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); and
- must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you; and

The relationship between you and City and County of San Francisco is that of employer and employee, Dependent or other classification as defined in this SPD.

Interpretation of Benefits

San Francisco Health Service System and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications; and
- make factual determinations related to the Plan and its Benefits.

The San Francisco Health Service System and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the San Francisco Health Service System may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the San Francisco Health Service System does so in any particular case shall not in any way be deemed to require the San Francisco Health Service System to do so in other similar cases.

Information and Records

The San Francisco Health Service System and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The San Francisco Health Service System and UnitedHealthcare may request additional

information from you to decide your claim for Benefits. The San Francisco Health Service System and UnitedHealthcare will keep this information confidential. The San Francisco Health Service System and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the San Francisco Health Service System and UnitedHealthcare with all information or copies of records relating to the services provided to you. The San Francisco Health Service System and UnitedHealthcare 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. The San Francisco Health Service System and UnitedHealthcare agree that such information and records will be considered confidential.

The San Francisco Health Service System 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 the San Francisco Health Service System is required to do by law or regulation. During and after the term of the Plan, the San Francisco Health Service System and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the San Francisco Health Service System recommends 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 UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the San Francisco Health Service System and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The

Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but San Francisco Health Service System recommends that you discuss participating in such programs with your Physician. You may also wish to consult your tax professional as well to determine if incentives you receive are considered taxable income. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

The San Francisco Health Service System and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The San Francisco Health Service System and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

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.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, Non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your Non-Network Physician or provider by going to <http://welcometouhc.com/sfhss> or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at <http://welcometouhc.com/sfhss> for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);
- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and

- zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the San Francisco Health Service System. The CRS program provides:

- specialized consulting services, on a limited basis, to Members and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD – see Congenital Heart Disease (CHD).

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

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – City and County of San Francisco and the San Francisco Health Service System.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which UnitedHealthcare determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, condition disease or its symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;
- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and

- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on <http://welcometouhc.com/sfhss> or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Member or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Member. No one can be a Dependent of more than one Member.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at <http://welcometouhc.com/sfhss> or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as defined by the HSS Rules.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

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

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and

validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; and
- serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency; and
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Employer – City and County of San Francisco.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare and the San Francisco Health Service System 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; (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational).
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying clinical trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare and the San Francisco Health Service System may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and the San Francisco Health Service System must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Fertility Solutions (FS) – a program administered by UnitedHealthcare or its affiliates made available to you by the San Francisco Health Service System. The FS program provides:

- Specialized clinical consulting services to Members and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

Gender Dysphoria – A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
 - ◆ A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 - ◆ A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 - ◆ A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - ◆ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - ◆ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - ◆ A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
 - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
 - ◆ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 - ◆ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 - ◆ A strong preference for cross-gender roles in make-believe play or fantasy play.
 - ◆ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
 - ◆ A strong preference for playmates of the other gender.
 - ◆ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls

(assigned gender), a strong rejection of typically feminine toys, games and activities.

- ◆ A strong dislike of ones' sexual anatomy.
- ◆ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- 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 Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including 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.

Intensive Behavioral Therapy – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

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

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

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

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

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the San Francisco Health Service System. The KRS program provides:

- specialized consulting services to Members and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

Member – a full-time employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Member must live and/or work in the United States.

Mental Health Services – Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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-Related and Addictive Disorders Administrator – the organization or individual designated by the San Francisco Health Service System who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

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

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

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by the San Francisco Health Service System, during which eligible Members may enroll themselves and their Dependents under the Plan. The San Francisco Health Service System determines the period of time that is the Open Enrollment period.

OptumInsight - provides technology and related services for the Plan.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician – any Doctor of Medicine or Doctor of Osteopathy 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 a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The San Francisco Health Service System City Plan PPO Medical Plan for Active Employees and Early Retirees.

Plan Administrator –The San Francisco Health Service System or its designee.

Plan Sponsor – The San Francisco Health Service System.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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

- no skilled services are identified;
- skilled nursing resources are available in the facility;

- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility 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-Related and Addictive Disorders Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- 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.

Retired Employee – an Employee who retires while covered under the Plan.

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.

Shared Savings Program - a program in which UnitedHealthcare may obtain a discount to a Non-Network provider's billed charges. This discount is usually based on a schedule

previously agreed to by the Non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the Non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are 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;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – an individual to whom you are legally married as defined by the HSS Rules.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living – Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through 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; or

- supervised living arrangements which are residences such as 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.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

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

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which 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.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at <http://welcometouhc.com/sfhss>.

Please note:

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

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and the San Francisco Health Service System's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person’s life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

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

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products;
- How to utilize the retail and mail order service for obtaining Prescription Drug Products;
- Any benefit limitations and exclusions that exist for Prescription Drug Products; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Copay amounts that apply when you have a prescription filled at a Network or Non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply	100% after you pay a:	50% after you pay a:
■ tier-1	\$10 Copay	\$10 Copay
■ tier-2	\$25 Copay	\$25 Copay
■ tier-3	\$50 Copay	\$50 Copay
Mail order - up to a 90-day supply	100% after you pay a:	
■ tier-1	\$20 Copay	Not Covered
■ tier-2	\$50 Copay	Not Covered
■ tier-3	\$100 Copay	Not Covered

Benefits for Preventive Care Medications		
Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under <i>Glossary – Prescription Drug Products</i> . You may determine whether a drug is a Preventive Care Medication through the internet at http://welcometouhc.com/sfhss or by calling UnitedHealthcare at the toll-free telephone number on your ID card.		
Covered Health Services^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Prescription Drug Products for Infertility	50%	50%
Prescription Drug Products for Smoking Cessation²	100%	Not Covered

¹You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drug Products. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

²Supply limits of two 90-day cycles per calendar year apply to tobacco cessation products.

³ Both Prescription and certain over-the-counter products are covered with prior notification. Your health care Provider will need to confirm that you are also getting counseling for tobacco cessation. See *Notification Requirements* in this section for details.

In addition, to be eligible for 100% coverage of certain tobacco cessation products, you must:

- be 18 years of age or older;
- obtain a prescription for these products, even if sold over-the counter; and
- fill the prescription at a Network pharmacy.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drug Products as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

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 the Claims Administrator during regular business hours.

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

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *How to File a Claim*. When you submit a claim on this basis, you may pay

more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit <http://welcometouhc.com/sfhss> or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a Non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay;

- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay; or
- the Prescription Drug Charge for that particular Prescription Drug Product.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto <http://welcometouhc.com/sfhss>.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drug Products:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form,

or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drug Products:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Want to lower your out-of-pocket Prescription Drug Product costs?

Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Designated Pharmacy

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug Product placement in tiers. In its evaluation of each Prescription Drug Product, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug Product; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

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

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

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug benefit.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug Product, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

The Plan may also require you to notify UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Non-Network Pharmacy, you or your Physician are responsible for notifying the Claims Administrator as required.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at a Non-Network Pharmacy. If UnitedHealthcare is not notified before you purchase the Prescription Drug Product, you can request reimbursement after you receive the Prescription Drug Product - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drugs from a Non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any Deductible that applies.

The following require prior notification:

- Prescription Drug Products prescribed for appetite suppression, and other weight loss products; and
- growth hormone therapy.

To determine if other Prescription Drug Products require notification, either visit <http://welcometouhc.com/sfhss> or call the toll-free number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at <http://welcometouhc.com/sfhss> or by calling the toll-free number on your ID card.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

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

Supply Limits

Some Prescription Drug Products are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug Product has been assigned a maximum quantity level for dispensing, either visit <http://welcometouhc.com/sfhss> or call the toll-free number on your ID card. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Drug may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

Prescription Drugs that are Chemically Equivalent

If two drugs are chemically equivalent (they contain the same active ingredient) and you choose not to substitute a lower tiered drug for the higher tiered drug, you will pay the difference between the higher tiered drug and the lower tiered drug, in addition to the lower tiered drug's Copayment and/or Coinsurance. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier.

Special Programs

The San Francisco Health Service System and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet

at <http://welcometouhc.com/sfhss> or by calling the number on the back of your ID card.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings to you, your Physician or your pharmacy that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug Product regimen is appropriate for your medical condition.

Coupons: UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at <http://welcometouhc.com/sfhss> or by calling the number on your ID card.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section. In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drug Products, you can access <http://welcometouhc.com/sfhss> through the Internet or by calling the telephone number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

1. 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;
2. any Prescription Drug Product for which 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;
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product, or

it is an over-the-counter drug and/or treatment for female contraception, and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

5. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a prescription order or refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3);
6. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
7. growth hormone for children with familial short stature based on heredity and not caused by a diagnosed medical condition);
8. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
9. the amount dispensed (day's supply or quantity limit) which is less than the minimum supply limit;
10. certain Prescription Drug Products that have not been prescribed by a specialist physician;
11. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
12. prescribed, dispensed or intended for use during an Inpatient Stay;
13. Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that San Francisco Health Service System determines do not meet the definition of a Covered Health Service;
14. a Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;
15. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year,

and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

16. certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;
17. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
18. unit dose packaging of Prescription Drug Products;
19. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and San Francisco Health Service System have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;
20. used for cosmetic purposes;
21. Prescription Drug Product as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed;
21. vitamins, except for the following which require a prescription:
 - prenatal vitamins;
 - vitamins with fluoride; and
 - single entity vitamins.
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
23. Dental products, including but not limited to prescription fluoride topicals.
24. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or MAC List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from Non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or MAC List price for Non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Out-of-Network Reimbursement Rate or MAC List price of the chemically equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Prescription Drug Products.

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

Generic - a Prescription Drug Product that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name 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 the Claims Administrator.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drug Products to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drug Products; and
- been designated by the Claims Administrator as a Network Pharmacy.

Out-of-Network Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Prescription Drug Product(s)- a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
 - standard insulin syringes with needles;
 - blood testing strips - glucose;
 - urine testing strips - glucose;
 - ketone testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your SPD.

Prescription Drug Charge – the rate the Claims Administrator has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto <http://welcometouhc.com/sfhss>.

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

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

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

You may determine whether a drug is a Preventive Care Medication through the internet at <http://welcometouhc.com/sfhss> or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Specialty Prescription Drug - Prescription Drug Product that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Infertility. For more information, visit <http://welcometouhc.com/sfhss> or call UnitedHealthcare at the toll-free number on your ID card.

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

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

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:

- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is San Francisco Health Service System, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - NOTICES

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.

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

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

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

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

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc.

When the Plan uses the words "Plan Sponsor" in this Attachment, it is a reference to the San Francisco Health Service System, on behalf of itself and its affiliated companies.

The Claims Administrator and the Plan Sponsor on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- The Claims Administrator and the Plan Sponsor provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
 - Provides free language services to people whose primary language is not English, such as: Qualified interpreters
 - Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator and Plan Sponsor have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
UnitedHealthcare Service LLC Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

Plan Sponsor Civil Rights Coordinator

Luenna Kim, Civil Rights Coordinator
City and County of San Francisco
San Francisco Human Services Agency
P.O. Box 7988 San Francisco, CA 94120-7988
(415) 557-5751 TTY 711
luenna.kim@sfgov.org

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m. PST.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, գանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնություն (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n’amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomeru ya telephone y’ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k’umugambi wawe w’ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূন্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ရန်လိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃសំរាប់សមាជិក ដែលមានកំណត់ក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4᠘ ᠆P ᠠCZ᠖᠕ ᠠ4᠙᠔᠕ ᠠA᠑W ᠠ᠖ ᠠ᠖᠑᠖ ᠠ᠗ ᠆R ᠠᠠᠠᠠ ᠠC᠙᠔᠕ ᠠ᠖ᠠ᠙᠔᠕ᠠᠠ, ᠆ᠠ᠖᠙᠔᠕ ᠐. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu h᠒ ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha ch᠒ hokmvt ch᠒ achukm᠗ka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila h᠒ ish ᠒paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoorra fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono‘ī me ka uku ‘ole ‘ana. E kama‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हेल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa imuta asusụ gi n’efu n’akwughị ugwo. Maka ikpoturu onye nsughari okwu, kpoo akara ekwentị nke di n’akwukwo njirimara gi nke emere maka ahụike gi, pia 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ဖၢၣ်လၢနကးနးန့ၢ်ဘၣ်တၢ်ဖၢၣ်စးစးနးန့ၢ်တၢ်ဂၢၢ်တၢ်ဂၢၢ်လၢနကးန့ၢ်ဒၣ်န့ၢ်လၢတၢ်လိၣ်ဟ့ၣ်အပူၤဘၣ်န့ၢ်လိၣ်လၢတၢ်ကယုန့ၢ်ပုၤကတိၤကိၤဖဲတၢ်တၢ်အဂီၢ်ကိၤတၢ်လိၣ်တဲၤအဂီၢ်လၢကရၢဖိအတၢ်လိၣ်ဟ့ၣ်အပူၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ဆူၣ်အတၢ်ရဲၣ်တၢ်က့ၢ်အကးအလိၣ်ဒီးဆိၣ်လိၣ်န့ၢ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافه‌ی ئه‌وه‌ت هه‌یه که بێهه‌رامبه‌ر، یارمه‌تی و زانیاری پێویست به‌ زمانی خۆت وهرگریت. بۆ داواکردنی وهرگیرتیکی زارمکی، په‌یوه‌ندی بکه به‌ ژماره‌ تله‌فۆنی نوسراو له‌ناو ئای دی کارتی پیناسیعی پلانی ته‌ندروستی خۆت و پاشان 0 داگره‌ .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ, ໂທພຣິຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ, ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबद्ध केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im mejeje ilo kajin eo aṃ ilo ejje!ok wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūr!ok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bááh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee níká'e'eyeego bee ná'ahoot'l'. 'Ata' halne'i ła yíníkeedgo, ninaaltsos nit['iz7 'ats'77s bee baa' ahay1 bee n44hazin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíílnih dóó 0 bíł 'adidíłchíł. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाउँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिचुहोस्। TTY 711
38. Nilotic-Dinka	Yín nōŋ lōŋ bē yi kuōny nē wēřēyic de thōŋ du ābac ke cin wēu tāāue ke piny. Ācān bā ran yē kōc ger thok thiēc, ke yín cōl nāmba yene yup abac de ran tōŋ ye kōc wāār thok tō nē ID kat duōn de pānakim yic, thāny 0 yic. TTY 711.
39. Norwegian	Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kansch du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਰੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711

Language	Translated Taglines
55. Thai	<p>คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา</p> <p>โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711</p>
56. Tongan-Fakatonga	<p>‘Oku ke ma’u ‘a e totonu ke ma’u ‘a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711</p>
57. Trukese (Chuukese)	<p>Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.</p>
58. Turkish	<p>Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711</p>
59. Ukrainian	<p>У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711</p>
60. Urdu	<p>آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711</p>
61. Vietnamese	<p>Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711</p>
62. Yiddish	<p>איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל, דרוקט 0. TTY 711</p>
63. Yoruba	<p>O ní ẹtọ lati rí iranwọ àti ifitónilétí gbà ní èdè rẹ láìsanwọ. Látí bá ògbufọ kan sọrọ, pè sọrí nọmbà ẹrọ ibánisọrọ láìsanwọ ibodè ti a tò sọrí kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711</p>

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at www.Unitedhealthallies.com or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.Unitedhealthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).

