CALIFORNIA

UnitedHealthcare®

# UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Schedule of Benefits
25-40/250D

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

## General Features

| | |
|---|---|
| Calendar Year Deductible | None |
| Maximum Benefits | Unlimited |
| Annual Copayment Maximum[1] (2 individual maximum per family[6]) | $2,500/individual |
| PCP Office Visits | $25 Office Visit Copayment |
| Specialist Office Visits[2] (Member required to obtain referral to specialist, except for OB/GYN Physician services and Emergency/Urgently Needed Services) | $40 Office Visit Copayment |
| Hospital Benefits *(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day)* | $250 Copayment per day Copayment applies to a maximum of 3 days per stay |
| Emergency Services (Copayment waived if admitted) | $150 Copayment |
| Urgently Needed Services (Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted) | $75 Copayment |
| Pre-Existing Conditions | All conditions covered, provided they are covered benefits |

## Benefits Available While Hospitalized as an Inpatient

| | |
|---|---|
| Bone Marrow Transplants | $250 Copayment per day Copayment applies to a maximum of 3 days per stay |
| Clinical Trials[3] | Paid at negotiated rate Balance (if any) is the responsibility of the Member |
| Hospice Services (Prognosis of life expectancy of one year or less) | $250 Copayment per day Copayment applies to a maximum of 3 days per stay |
| Hospital Benefits[4] *(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day)* | $250 Copayment per day Copayment applies to a maximum of 3 days per stay |
| Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy) | $250 Copayment per day Copayment applies to a maximum of 3 days per stay |
| Maternity Care[8] | $250 Copayment per day Copayment applies to a maximum of 3 days per stay |

## Benefits Available While Hospitalized as an Inpatient (Continued)

| | |
|---|---|
| Mental Health Services<br>(As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)** **(Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day)** | $250 Copayment per day<br>Copayment applies to a maximum of 3 days per stay |
| Newborn Care[4] | $250 Copayment per dayCopayment applies to a maximum of 3 days per stay |
| Physician Care | Paid in full |
| Reconstructive Surgery | $250 Copayment per day<br>Copayment applies to a maximum of 3 days per stay |
| Rehabilitation Care<br>(Including physical, occupational and speech therapy) | $250 Copayment per day<br>Copayment applies to a maximum of 3 days per stay |
| Skilled Nursing Facility Care<br>(Up to 100 days per benefit period) | $250 Copayment per day |
| Termination of Pregnancy<br>(Medical/medication and surgical) | $125 Copayment |

## Benefits Available on an Outpatient Basis

| | |
|---|---|
| Allergy Testing/Treatment<br>(Serum is covered)<br>PCP Office Visit<br>Specialist Office Visit | <br><br>$25 Office Visit Copayment<br>$40 Office Visit Copayment |
| Ambulance<br>(Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment.) | $100 Copayment |
| Clinical Trials[3] | Paid at negotiated rate<br>Balance (if any) is the responsibility of the Member |
| Cochlear Implant Devices[5]<br>(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply) | $40 Copayment per item |
| Dental Treatment Anesthesia<br>(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply) | $40 Copayment |
| Dialysis<br>(Physician office visit Copayment may apply) | $40 Copayment per treatment |
| Durable Medical Equipment[5] | 20% Copayment |
| Durable Medical Equipment for the Treatment of Pediatric Asthma<br>(Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19.) | 20% Copayment |
| Family Planning (Non-Preventive Care)[9]<br>Vasectomy<br>Depo-Provera Injection – (other than contraception)[9]<br>PCP Office Visit<br>Specialist Office Visit<br>Depo-Provera Medication – (other than contraception)[9]<br>(Limited to one Depo-Provera injection every 90 days.)<br>Termination of Pregnancy<br>(Medical/medication and surgical) | <br>$50 Copayment<br><br>$25 Office Visit Copayment<br>$40 Office Visit Copayment<br>$35 Copayment<br><br>$125 Copayment |

## Benefits Available on an Outpatient Basis (Continued)

| | |
|---|---|
| Hearing Aid - Standard<br>($5,000 benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years.) | 20% Copayment |
| Hearing Aid - Bone Anchored[7]<br>(Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.) | Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits. |
| Hearing Exam[2,8] | |
| PCP Office Visit | $25 Office Visit Copayment |
| Specialist Office Visit[2] | $40 Office Visit Copayment |
| Home Health Care Visits<br>(Up to 100 visits per calendar year) | $25 Copayment per visit |
| Hospice Services<br>(Prognosis of life expectancy of one year or less) | Paid in full |
| Infertility Services | Not covered |
| Infusion Therapy[5]<br>(Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter) | $150 Copayment |
| Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)[5,9]<br>(Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply) | 30% up to $150 Copayment per visit |
| Laboratory Services<br>(When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply) | Paid in full |
| Maternity Care, Tests and Procedures[8] | |
| PCP Office Visit | Paid in full |
| Specialist Office Visit | Paid in full |
| Mental Health Services<br>(As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**) | $40 Office Visit Copayment |
| Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility<br>(Including physical, occupational and speech therapy) | $25 Office Visit Copayment |
| Oral Surgery Services[5] | $100 Copayment |
| Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility | $200 Copayment |
| Physician Care | |
| PCP Office Visit | $25 Office Visit Copayment |
| Specialist Office Visit | $40 Office Visit Copayment |

## Benefits Available on an Outpatient Basis (Continued)

| | |
|---|---|
| Preventive Care Services[8,9]<br>(Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.)<br>Covered Services will include, but are not limited to, the following:<br>• Colorectal Screening<br>• Hearing Screening<br>• Human Immunodeficiency Virus (HIV) Screening<br>• Immunizations<br>• Newborn Testing<br>• Prostate Screening<br>• Vision Screening<br>• Well-Baby/Child/Adolescent Care<br>• Well-Woman, including routine prenatal obstetrical office visits<br>Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. | Paid in full |
| Prosthetics and Corrective Appliances[5] | 20% Copayment |
| Radiation Therapy[5] | |
| Standard:<br>(Photon beam radiation therapy) | Paid in full |
| Complex:<br>(Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any) | $50 Copayment |
| Radiology Services[5] | |
| Standard<br>(Additional Copayment for office visits may apply): | Paid in full |
| Specialized scanning and imaging procedures:<br>(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)<br>A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure. | $100 Copayment |
| Vision Refractions | |
| PCP Office Visit | $25 Office Visit Copayment |
| Specialist Office Visit | $25 Office Visit Copayment |

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

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

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

[3]Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[4]The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

[5]In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate. (This footnote only applies to dollar copayments.)

[6]When an individual member meets the Annual Copayment Maximum no further copayments are required for the year for that individual.

[7] Bone anchored hearing aid will be subject to applicable medical/surgical categories (.e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Replacement of external hearing aid components are covered under the Durable Medical Equipment benefit. Deluxe model and upgrades that are not medically necessary are not covered.

[8]Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

[9]FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.

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

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

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

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

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


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THE J PAUL GETTY TRUST

UnitedHealthcare®

# UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Pharmacy Schedule of Benefits

| Summary of Benefits | Generic Formulary | Brand-name Formulary | Non-Formulary |
|---|---|---|---|
| Retail Pharmacy Copayment (per Prescription Unit or up to 30 days) | $15 | $35 | $50 |
| Mail Service Pharmacy Copayment (three Prescription Units or up to a 90-day supply) | $30 | $70 | $100 |

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

## What do I pay when I fill a prescription?

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

There are selected brand-name medications where you will pay a generic Copayment of just $15. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's Web site at **www.myuhc.com**.

## Preauthorization

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

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

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

## Medication Covered by Your Benefit

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

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

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

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

## Exclusions and Limitations

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

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

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

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

UnitedHealthcare. For information on UnitedHealthcare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits, in the section titled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our Web site at **www.myuhc.com**.

- **Therapeutic devices or appliances,** including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as Durable Medical Equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation**: Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about workers' compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Six under "Payment Responsibility."

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

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

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

**Customer Service:**
**800-624-8822**
**711 (TTY)**
**www.myuhc.com**


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CALIFORNIA

UnitedHealthcare®

# Chiropractic Schedule of Benefits Offered by ACN Group of California, Inc.

## Benefit Plan:

**$15 Copayment per Visit**

**30 Visit Annual Maximum Benefit**

UnitedHealthcare of California makes available to you and your eligible dependents programs that are included as part of your coverage chiropractic benefit. This program is provided through an arrangement with the ACN Group of California, Inc. d/b/a OptumHealth Physical Health of California (OptumHealth).

## How to Use the Program

With this benefit, you have direct access to more than 3,000 credentialed chiropractors servicing California. You are not required to predesignate a Participating Provider or to obtain a medical referral from your primary care physician prior to seeking chiropractic services. Additionally, you may change participating chiropractors at any time.

If these services are covered services, you simply pay your copayment or coinsurance at each visit. There are no deductibles or claim forms to fill out. Your Participating Provider coordinates all services and billing directly with OptumHealth. Members are responsible for any changes resulting from non-covered services.

## Annual Benefits

Benefits include chiropractic services that are Medically Necessary services rendered by an Optum Health Participating Provider. In the case of chiropractic services, the services must be for Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

## Calculation of Annual Maximum Benefit Limits

Each visit to a Participating Provider, as described below, requires a copayment by the Member. A maximum number of visits per year will apply to each member.

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

## Provider Eligibility

OptumHealth only contracts with duly licensed California chiropractors. Members must use OptumHealth Participating Providers to receive their maximum benefit.

## Types of Covered Services

### Chiropractic Services:

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

   Subsequent office visits, as set forth in the treatment plan, may involve a chiropractic adjustment, a brief re-examination and/or a combination of services. A copayment will be required for each office visit.
2. Adjunctive therapy, as set forth the treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.
3. A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.
4. X-rays and laboratory tests are a covered benefit in order to examine any aspect of the member's condition.
5. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by an OptumHealth participating chiropractor.

## Important OptumHealth Addresses:

Member Correspondence

ACN Group of California, Inc.
Attn.: Member Correspondence Unit
P.O. Box 880009
San Diego, CA 92168

Grievances and Complaints

ACN Group of California, Inc.
Attn.: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168

## Exclusions and Limitations

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

1. Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Any accommodation, service, supply or other item that are not related to the member's condition, not likely to result in sustained improvement, or do not have defined endpoints, including maintenance, preventive or supportive care.
4. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;
5. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
6. Experimental or investigative services unless required by an external, independent review panel as described in 16.5 of the EOC;
7. Services provided at a hospital or other facility outside of a Participating Provider's facility;
8. Holistic or homeopathic care including drugs and ecological or environmental medicine;
9. Services involving the use of herbs and herbal remedies;
10. Treatment for asthma or addiction (including but not limited to smoking cessation);
11. Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;
12. Transportation to and from a provider;
13. Drugs or medicines;
14. Intravenous injections or solutions;
15. Charges for services provided by a Provider to his or her family Member(s);
16. Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
17. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
18. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;
19. Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services or Urgent Services, or other services authorized by Health Plan;
20. Ambulance services;
21. Surgical services;
22. Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;
23. Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child; and
24. Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Medical Emergencies are covered by the Member's medical plan.

**ACN Group's Web site Address:**
**http://www.myoptumhealthphysicalhealthofca.com**

**Customer Service:**
**1-800-624-8822**
**711 (TTY)**
**www.uhcwest.com**