Evidence of Coverage and Disclosure Information

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University of California
MedicareComplete® Retiree Plan

California
H0543

Effective January 1, 2007
through December 31, 2007

Offered by PacifiCare®

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Your Rights Under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including the Group Service Agreement. Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

This Evidence of Coverage and Disclosure Information contains the terms and conditions of coverage, along with the Retiree Benefits Summary and rights you have with the MedicareComplete® Retiree Plan, offered by UnitedHealthcare.® All applicants have a right to view this document prior to enrollment. This information should be read completely and carefully. Individuals with special needs should carefully read those sections that apply to them. This document will be mailed to you annually.

This document is effective January 1, 2007, through December 31, 2007.

When the Agreement is purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Federal law mandates that UnitedHealthcare comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of federal funds, and all other applicable laws and rules. Specifically, UnitedHealthcare does not discriminate, neither in the employment of staff nor in the provision of health care services, on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin.

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Nondiscrimination Statement

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams and for faculty to Executive Director Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Any notices required to be given by us to the Member under this Evidence of Coverage and Disclosure Information shall be in writing, delivered by United States mail and sent to the Member at the address last known to us. Any notices required to be given to us by the Member under this Evidence of Coverage and Disclosure Information shall be in writing and be delivered either in person or by United States mail to the address below.

If you have any questions or need any additional information, call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m., Sunday through Saturday, or

Write:
Customer Service
P.O. Box 29800
Hot Springs, AR 71903-9800

Visit the Web site at
www.securehorizons.com

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Welcome to the MedicareComplete® Retiree Plan!

This document and the Retiree Benefits Summary explain your rights, benefits and responsibilities as a Member of MedicareComplete,® a SecureHorizons® Medicare Advantage retiree plan, offered by PacifiCare,® a UnitedHealthcare® company (hereinafter referred to as UnitedHealthcare). These documents also explain our responsibilities to you. Your Member contract for MedicareComplete consists of this Evidence of Coverage and Disclosure Information, the Retiree Benefits Summary, the Retiree Benefits Summary Insert, your Enrollment Application Form and any current or future amendments.

This Evidence of Coverage and Disclosure Information and the Retiree Benefits Summary contain important information. These documents will be mailed to you annually and will replace all prior Evidence of Coverage and Disclosure Information and Retiree Benefits Summary documents. Please read them carefully and keep them in a safe place, available for quick reference. If you have special needs, this document may be available in other formats. *(For spouses, dependents and early retirees who are not entitled to Medicare and who are enrolled in the PacifiCare Commercial Plan through your Plan Sponsor's selection of PacifiCare, please refer to the PacifiCare Evidence of Coverage.)*

We have entered into a contract with the Centers for Medicare & Medicaid Services (CMS), the federal governmental agency that administers Medicare. The contract with CMS authorizes us to arrange for comprehensive health services for individuals who are entitled to Medicare benefits and who choose to enroll in MedicareComplete. When you join MedicareComplete, you usually do not pay Medicare deductibles and Coinsurance charges, but instead, you may pay Health Plan Premiums, Copayments and Coinsurance. MedicareComplete covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare. PacifiCare is also licensed by the State Department of Insurance.

We have signed contracts with CMS agreeing to cover you for one calendar year at a time. MedicareComplete costs and benefits may change from year to year, and we will notify you before any changes are made. In general, your benefits will not change during the calendar year. (Your Plan Sponsor may modify your benefits mid-year during the calendar year, with written notice.) In addition, either CMS or we may choose not to renew all or a portion of the contract. If the contract is not renewed, your Medicare coverage will be switched to Original Medicare, unless you decide to choose another Medicare Advantage plan. If either CMS or we decide not to renew the contract at the end of the year, you will receive a letter at least ninety (90) days before the end of the contract. If CMS ends the contract in the middle of the year, you will receive a letter at least thirty (30) days before the end of the contract. In either situation, the letter will explain your options for health care coverage in your area and provide information about your right to obtain Medicare supplemental insurance coverage.

By enrolling in MedicareComplete, you have agreed to receive your health care services from Contracting Medical Providers and facilities. You are required to follow all plan rules, such as obtaining Referrals and Prior Authorization, when required.

If you need Emergency Services (anywhere in the world) or Urgently Needed Services (generally, outside the area served under MedicareComplete), those services will be covered. However, **neither UnitedHealthcare nor Medicare will pay for services you receive from Non-Contracting Providers outside of this Service Area, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis or post-stabilization services.**

Call Customer Service When You Need Information

In addition to arranging health care services, we strive to provide the information you need about your MedicareComplete plan when you need it.

We have specially trained Customer Service Representatives who can answer your questions about:

- Covered Services
- Making address or telephone number changes
- Primary Care Physician selection and changes
- Enrollment or Disenrollment
- Appeal and Grievance complaint rights

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- Medical coverage when you are traveling
- The quality of care you are receiving
- Certain information concerning your physician
- Claims
- Any other questions or concerns regarding your MedicareComplete plan

Updating Your Enrollment Records

Your enrollment record contains information from your Enrollment Application Form, including your address and telephone number, as well as your specific benefit plan coverage and Primary Care Physician you selected upon enrollment. These records are very important, because they identify you as an eligible MedicareComplete plan Member and determine where and if you are eligible to receive Covered Services.

Please report any changes in name, address or phone number to Customer Service immediately. You must also report any changes in health insurance coverage you have from your employer or your spouse's employer. Additionally, you must report any liability claims (such as claims against another driver in an auto accident), eligibility under Workers' Compensation or Medicaid.

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We Are Interested in Your Comments

Our goal is to arrange the Covered Services you need to stay as healthy and active as you can. We are interested in your comments. From time to time, we will ask for your thoughts on MedicareComplete through voluntary Member satisfaction surveys. These surveys help us measure both the performance of MedicareComplete Contracting Medical Providers, as well as our ability to assist you with your health care coverage concerns.

How to Submit a Claim

All Covered Services prescribed by us will be billed directly to the plan. However, if you receive a bill for a Covered Service or Emergency Service you received from a Non-Contracting Medical Provider, please send the claim for determination of coverage to:

UnitedHealthcare Claims Department
P.O. Box 489
Cypress, CA 90630

You are responsible for paying any applicable Copayments or Coinsurance amounts directly to the Provider at the time of service. If you have any questions about any claims, please call Customer Service.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Dr., 12th Floor
Oakland, CA 94612
1-800-888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Section 1

Health Care Terms

The following definitions apply to this Evidence of Coverage and Disclosure Information:

Acute Care – Treatment for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma or during recovery from surgery. Acute Care is usually received in a Hospital from specialized personnel using complex and sophisticated technical equipment and materials. This pattern of care is often necessary for a short time, unlike chronic care, where no significant improvement can be expected.

Appeal – The type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service or what we will pay for a service. You may file an Appeal in the following instances:

- If we refuse to cover or pay for services you think we should cover
- If we or one of the Contracting Medical Providers refuses to provide a service you think should be covered
- If we or one of the Contracting Medical Providers reduces or cuts back on services you have been receiving

- If you think that we are stopping your coverage too soon

Basic Benefits – All health care services that are covered under the Medicare Part A and Part B programs (except Hospice services, which are covered by Medicare), additional services that we use Medicare funds to cover, and other services for which you may be required to pay a Health Plan Premium. All Members of MedicareComplete receive all Basic Benefits.

Benefit Period – A Benefit Period is a way of measuring your use of services under Medicare Part A. A Medicare Benefit Period begins with the first day of a Medicare-covered inpatient Hospital Stay, and ends with the close of a period of sixty (60) consecutive days, during which you were neither an inpatient of a Hospital or of a Skilled Nursing Facility. For MedicareComplete plan Members, Inpatient Hospital Care Copayments are charged either on a per admission basis or on a daily basis for a limited number of days. Original Medicare Hospital Benefit Periods do not apply. For Inpatient Hospital Care, you are covered for an unlimited number of days, as long as the Hospital Stay is Medically Necessary and authorized by us or Contracting Medical Providers.

Calendar Year – A twelve (12)-month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Centers for Medicare & Medicaid Services (CMS) – Federal agency responsible for administering Medicare.

Coinsurance – The percentage of the cost a Member is required to pay for a Covered Service.

Contracting Medical Groups/Independent Physicians Associations (IPAs) –

Contracting Medical Groups – Physicians organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has an agreement with us to provide medical services to Members.

Independent Physicians Associations (IPAs) – Organizations or affiliated groups of physicians that deliver or arrange for the delivery of health services and function as Contracting Medical Groups, with physicians practicing out of their own independent medical offices.

Contracting Medical Provider – A health professional, a supplier of health items or a health care facility having an agreement with us or a Contracting Medical Group/IPA, to provide or coordinate medical services to Members. Contracting Medical Providers are independent contractors and are not the employees or agents of UnitedHealthcare.

Contracting Provider – A health professional or a supplier of health items (such as a dentist, optometrist or chiropractor) having an agreement with us to provide or coordinate Covered Services to Members. Contracting Medical Providers are independent contractors and are not the employees or agents of UnitedHealthcare.

Contracting Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare), who has an agreement with us to provide health care services to Members for a specific disease, condition or body part.

Coordinated Care Plans – Medicare Advantage Plans that use a network of Providers, which are under contract or arrangement with a Medicare Advantage Organization or its Contracting Medical Groups/IPAs, to provide covered benefits. MedicareComplete is a Coordinated Care Plan.

Copayment – The fee you pay at the time of medical services in accordance with your MedicareComplete plan.

Covered Services – Those benefits, services and supplies listed in the Retiree Benefits Summary, which are:

- Services provided or furnished by Contracting Medical Providers or authorized by us or Contracting Medical Providers
- Emergency Services and Urgently Needed Services, for which you do not need Prior Authorization and which may be provided by Non-Contracting Providers. (Please refer to Section 6 for more information about Emergency Services and Urgently Needed Services.)
- Post-Stabilization services furnished by Non-Contracting Providers or facilities that are Prior Authorized by us, or were not Prior Authorized because we did not respond to a request for Prior Authorization for such services within one (1) hour of the request, or because we could not be contacted for Prior Authorization
- Renal Dialysis services provided while you are temporarily outside of the Service Area

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- Any services for which we provide Prior Authorization
- Services not specifically excluded in Section 10 — MedicareComplete Limitations and Exclusions

MedicareComplete covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare.

Custodial Care – Services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, using the toilet, bathing, dressing, feeding, preparation of special diets and supervision of the administration of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is not a Covered Service.

Customer Service – A department dedicated to answering your questions concerning (but not limited to) your membership, Covered Services, Grievances and Appeals.

Disenroll or Disenrollment – The process of ending your membership in MedicareComplete. Disenrollment may be voluntary or involuntary.

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Durable Medical Equipment (DME) – Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, Durable Medical Equipment must be Medically Necessary and prescribed by a Contracting Medical Provider for use in your home, such as oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines. Routine DME will not be covered when the Member has exhausted the one hundred (100) days Skilled Nursing Facility benefits and remains in an institution or distinct part of an institution meeting the basic requirements of a Hospital or Skilled Nursing Facility. The decision to rent or purchase a DME item is determined by your Primary Care Physician or UnitedHealthcare.

Effective Date – The date your MedicareComplete plan coverage begins. You receive written notification of your Effective Date from us.

Emergency Medical Condition – An Emergency Medical Condition is a medical condition recognizable by symptoms serious enough (including severe pain, serious injury) that a person with an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in: 1) placing your health at serious risk; 2) serious harm to bodily functions; 3) serious dysfunction of any bodily organ or part; 4) in the case of a pregnant woman, an Emergency Medical Condition exists if the pregnant woman is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is not enough time to safely transfer the pregnant woman to another hospital before delivery; or b) a transfer may pose a threat to the health and safety of the pregnant woman or the unborn child.

Emergency Services – Covered Services that are 1) furnished by a Provider qualified to furnish Emergency Services and 2) needed to evaluate or stabilize a medical emergency. (See the definition of Emergency Medical Condition.)

Enrollment Application Form – The enrollment form a Medicare beneficiary or legal representative must complete (with your signature and date) in order to be enrolled as a Member of the MedicareComplete Retiree Plan. This form is submitted to CMS for approval.

Evidence of Coverage and Disclosure Information – A document that explains Covered Services and defines your rights and responsibilities as a Member, and those of UnitedHealthcare.

Exclusion or Excluded – Items or services that are not covered under this Evidence of Coverage and Disclosure Information and Retiree Benefits Summary. Benefit specific Exclusions are disclosed in the Retiree Benefits Summary. You are responsible for paying for excluded items or services. (See Section 10 for the list of MedicareComplete Exclusions.)

Experimental and Investigational Services and Items – May include any procedure, study, test, drug, equipment or facility still undergoing study and for which there is not FDA and CMS

approval. Any interpretation for specific cases must rely on and be consistent with Medicare Rules, Statutes, Federal Regulations, CMS Program Manuals, and other publications by CMS that are in place (including all CMS National Coverage Decisions) at the time the services are provided and that apply to the specific procedure, drug, or item requested.

Grievance – The type of complaint you make if you have a complaint or problem that does not involve payment or provision of services by us or a Contracting Medical Provider. For example, you would file a Grievance if you have a problem with things such as the quality of your care, general dissatisfaction with the way MedicareComplete benefits are designed, waiting times for appointments or in the waiting room, the way your doctors or others behave, not being able to reach someone by phone or obtain the information you need, or the lack of cleanliness or the condition of the doctor's office.

Health Plan Premium – The monthly payment to UnitedHealthcare, *if applicable*, along with the Medicare Part B Premium and Medicare Part A Premium, paid to Medicare, *if applicable*, that entitle you to the Covered Services outlined in this Evidence of Coverage and Disclosure Information. MedicareComplete benefit plans that offer Medicare Part D prescription drug coverage may also have a Medicare Part D Premium.

Home Health Agency – A Medicare-certified agency, which provides intermittent Skilled Nursing Care and other Medically Necessary therapeutic services in your home, when you are confined to your home, and when authorized by your Primary Care Physician or Contracting Medical Provider.

Hospice – An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital – A Medicare-certified institution licensed by the State, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility, or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Hospital Stay – A Hospital Stay commences on the first day of Covered Services in an Acute Care Hospital. A Hospital Stay ends when the Member is either discharged from the Hospital or transferred to another level of care, for example, home health care or Skilled Nursing Facility. If a Member subsequently transfers from an Acute Care Hospital to a Skilled Nursing Facility; a Skilled Nursing Facility to an Acute Care Hospital; or Home Health Agency to an acute or Skilled Nursing Facility, another applicable Copayment period begins.

Hospitalist – When you are admitted for a Medically Necessary procedure or treatment at a Network Hospital, your health care may be coordinated by a physician who specializes in treating inpatients (patients in a Hospital). This allows your Primary Care Physician or Contracting Medical Provider to continue to see other patients in his or her office, while you are hospitalized.

Independent Review Entity – An entity under contract with CMS which reviews Appeals by members of Medicare Advantage plans, including MedicareComplete.

Lock-In Feature – An arrangement under which all Covered Services, with the exception of Emergency Services, Urgently Needed Services, out-of-area and routine travel renal dialysis or post-stabilization services, must be provided by your Contracting Medical Provider or your Primary Care Physician. If you receive services from a Non-Contracting Medical Provider or Facility, or a Contracting Medical Provider such as a Specialist, without Prior Authorization from us or your Contracting Medical Group/IPA, neither UnitedHealthcare nor Medicare will pay for that care. There are very limited exceptions to this rule. See the Retiree Benefits Summary for specific limitations that apply.

Medicaid – A joint federal/State medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medicaid. Unlike Medicare, Medicaid can cover long-term care, such as Custodial Care. Medicaid can cover all or part of your Medicare premiums and/or deductibles and Coinsurance, if your income and resources fall below specific levels. You may inquire about Medicaid and related programs — Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual and Qualified Individual — at your local department of human services.

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Medical Director – A licensed physician who is an employee of UnitedHealthcare and is responsible for monitoring and overseeing the quality of care to MedicareComplete plan Members.

Medically Necessary or Medical Necessity – A health intervention will be covered under the MedicareComplete Health Plan if it is an otherwise Covered Service, not an Excluded service, and *Medically Necessary*. An intervention may be medically indicated yet not be a covered benefit or meet the definition of *Medical Necessity*. An intervention is *Medically Necessary* if, as recommended by the treating physician and determined by the Medical Director of UnitedHealthcare, it is all of the following:

(a) A health intervention for the purpose of treating a medical condition;

(b) The most appropriate supply or level of service, considering potential benefits and harms to the Member;

(c) Known to be effective in treating the medical condition. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

(d) If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner, which may be provided safely and effectively to the Member.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

(i) A ***health intervention*** is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A ***medical condition*** is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined by the intervention itself, the medical condition and the patient indications for which it is being applied.

(ii) ***Effective*** means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(iii) ***Scientific evidence*** consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Such studies do not, by themselves, demonstrate a causal relationship, unless the magnitude of the effect observed exceeds anything that could be explained, either by the natural history of the medical condition, or potential experimental biases. For existing interventions, the scientific evidence should be considered first, and to the greatest extent possible, should be the basis for determination of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence, if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

(iv) A ***new intervention*** is one which is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (such as rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If

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professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

(v) An intervention is considered ***cost effective*** if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition.

Medicare (Original Medicare) – The federal government health insurance program established by Title XVIII of the Social Security Act for people 65 years of age or older, certain younger people with disabilities and people with end-stage renal disease (ESRD).

Medicare Advantage Organization (MAO) – A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting Medicare Advantage requirements. MAOs can offer one or more Medicare Advantage Plans. PacifiCare is an MAO.

Medicare Advantage Plan – A policy or benefit package offered by a Medicare Advantage Organization, under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area covered by the Medicare Advantage Plan. An MAO may offer more than one Medicare Advantage Plan in the same Service Area.

MedicareComplete Retiree Plan – A Medicare Advantage Plan offered by PacifiCare, a Medicare Advantage Organization.

Medicare Part A – Hospital insurance benefits, including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part A Premium – Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. Generally, people age 65 and older may obtain premium-free Medicare Part A benefits based on their own or their spouse's employment. If you are under 65, you may obtain premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security or the Railroad Retirement Board (1-800-808-0772, TTY (312) 751-4701) for more than 24 months. If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. Also, you may be able to buy Medicare Part A if you are disabled and lost your premium-free Part A because you are working. You may contact the Social Security Administration Office at 1-800-772-1213 toll-free, (TTY 1-800-325-0778 toll-free). You also may visit the Social Security Web site at *www.ssa.gov*.

Medicare Part B – Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B Premium – A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services, whether a Medicare Advantage Plan or Medicare covers you. If you are eligible for a Medicare Savings Program, the State may pay all or part of your Medicare Part B Premium.

Medicare Part D – A voluntary prescription drug benefit program approved by Medicare and offered to Medicare beneficiaries through Medicare Advantage Organizations, such as UnitedHealthcare, which offers MedicareComplete and through stand alone Prescription Drug Plans. Please refer to your Retiree Benefits Summary to determine your coverage.

Medicare Part D Premium – A monthly premium paid to Medicare Part D providers, such as UnitedHealthcare, (may be deducted from your Social Security check) to cover Part D prescription drug coverage. Not all MedicareComplete Medicare Advantage benefit plans that offer Medicare Part D prescription drug coverage have a Medicare Part D Premium. Not all MedicareComplete plans have Medicare Part D prescription drug coverage. Please refer to your Retiree Benefits Summary to determine your coverage.

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Medicare Savings Program – A program usually administered by Medicaid State agencies, which offers assistance to low income Medicare beneficiaries. This type of program includes Medicare beneficiaries who qualify as a Medicaid Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual.

Member ("MedicareComplete Retiree Plan Member") – You, the Medicare-eligible retired employee, and your Medicare-eligible dependents who meet the eligibility requirements of your Plan Sponsor for enrollment in the employer-sponsored group retiree health plan available through UnitedHealthcare and whose enrollment has been confirmed by CMS, and thus is entitled to receive Covered Services.

Network – Providers, facilities and Hospitals contracted by UnitedHealthcare to deliver the Covered Services provided for in this Evidence of Coverage and Disclosure Information and Retiree Benefits Summary.

Network Hospital – A Hospital that has a contract with UnitedHealthcare to provide services and supplies to MedicareComplete plan Members.

Non-Contracting Medical Provider or Facility – Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services, and who is neither employed, owned, operated by, nor under contract with UnitedHealthcare to deliver Covered Services to MedicareComplete plan Members.

Non-Contracting Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare), who provides health care services for a specific disease, condition or body part, who is neither employed by nor under contract with UnitedHealthcare to deliver Covered Services to you. Also any duly licensed emergency room physician who provides Emergency Services to you.

Office Visit – A visit for Covered Services to your Primary Care Physician, Contracting Specialist, Nurse Practitioner, Physician's Assistant, Psychologist, Coumadin Clinic, other Contracting Medical Provider, and with Prior Authorization a Non-Contracting Medical Provider.

Optional Supplemental Benefits (If applicable) – Your Plan Sponsor may have elected to offer (or endorse) these additional benefits. Refer to your Retiree Benefits Summary. Non-Medicare covered benefits that may be purchased beyond the benefits included in the basic MedicareComplete plan, which may be elected at a Member's option. There is a Plan Premium associated with Optional Supplemental Benefits. Members of MedicareComplete must voluntarily elect Optional Supplemental Benefits in order to receive them.

Outpatient Services – Ambulatory medical services received by a Member when the Member is not admitted to a Hospital or Skilled Nursing Facility.

Plan Sponsor – The University of California.

Prescription Drug Plans – Medicare approved stand-alone drug plans that only cover Medicare Part D prescription drugs, not other benefits or services.

Primary Care Physician – The Contracting Medical Provider whom you choose and who is responsible for providing or authorizing Covered Services while you are a Member of MedicareComplete. Primary Care Physicians are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

Prior Authorization – A system whereby a Provider must receive approval from us or your Contracting Medical Group/IPA before you, the Member, receive certain Covered Services. Among other services, all services rendered by Non-Contracting Medical Providers and Non-Contracting Specialists must have Prior Authorization, unless provided during an Emergency, or while you are temporarily out of the Service Area and need Urgent Care. Services requiring Prior Authorizations are listed in this Evidence of Coverage and in the Retiree Benefits Summary.

Provider – Any professional person, organization, health facility, Hospital or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Quality Improvement Organization (QIO) – An independent contractor paid by CMS to review Medical Necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. The QIO must review complaints about the quality of care given by physicians in

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inpatient Hospitals, outpatient Hospital facilities, Hospital emergency rooms, Skilled Nursing Facilities, Home Health Agencies, ambulatory surgical centers and Private Fee-for-Service plans.

Referral – A formal recommendation by your Primary Care Physician for you to receive care from a Specialist or Contracting Medical Provider.

Retiree Benefits Summary – The document which provides the details of your particular benefit plan, including any Copayments and Coinsurance that you pay when receiving a Covered Service. Together with this Evidence of Coverage and Disclosure Information document, the Retiree Benefits Summary explains your health care coverage.

Service Area – A geographic area approved by CMS within which a Medicare Advantage eligible individual may enroll in a particular Medicare Advantage Plan offered by us. Service Areas may contain different benefit plans that offer different benefits, Health Plan Premiums, Copayment and Coinsurance amounts.

Skilled Nursing Care – Medically Necessary services that can only be performed by, or under the supervision of, licensed nursing personnel.

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Skilled Nursing Facility (SNF) – A facility that provides inpatient Skilled Nursing Care, rehabilitation services or other related health services, and is State licensed and/or certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily Custodial Care, including training in routines of daily living.

Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare), who provides health care services for a specific disease, condition or body part, to whom you may be referred to by your Primary Care Physician or Contracting Medical Provider. Also, any duly licensed emergency room physician who provides Emergency Services to you. Specialists may be Contracting Specialists or Non-Contracting Specialists.

State – The State in which the Member resides. The State is responsible for licensing UnitedHealthcare.

Time-Sensitive – A situation in which waiting for a standard decision on an authorization, request for services or an Appeal could seriously jeopardize your life, health, or your ability to recover from an illness, injury or condition.

UnitedHealthcare (the Plan) – Within this document, UnitedHealthcare refers to PacifiCare. PacifiCare is a State corporation that is organized and licensed by the State as a risk-bearing entity and is certified by CMS as meeting Medicare Advantage requirements. PacifiCare is a Medicare Advantage Organization that offers MedicareComplete plans. We, us and our, when used in this document, refer to PacifiCare.

Urgently Needed Services – Covered Services provided when you are temporarily absent from the MedicareComplete Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Contracting Medical Provider is temporarily unavailable or inaccessible), when such services are Medically Necessary and immediately required: 1) as a result of an unforeseen illness, injury or condition; and 2) it is not reasonable, given the circumstances, to obtain the services through your Contracting Medical Provider.

Utilization Review – A comprehensive, integrated process in which a team of health care professionals evaluates your treatment in an effort to promote the efficient use of resources and the quality of health care. Duties of the Utilization Review staff include Prior Authorization, concurrent and retrospective review of medical services.

Section 2

Eligibility, Enrollment Periods and Effective Date

The University of California establishes its own medical plan eligibility criteria for Retirees based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below. If you reside in the SecureHorizons Medicare Advantage (MA) Plan Service Area, and meet the University's and the Plan's eligibility criteria, you may enroll in the Plan.

Are You Eligible to Enroll in the MedicareComplete Retiree Plan?

To be able to enroll in MedicareComplete:

1. You must be entitled to Medicare Part A and enrolled in Medicare Part B. You must be enrolled in Medicare Part A and Medicare Part B as of the Effective Date of your enrollment in MedicareComplete.
2. You must meet the eligibility requirements of the University of California (Plan Sponsor).
3. You must not currently have end-stage renal disease or receive routine kidney dialysis. However, if either of these conditions should apply to you, in some instances, you may be eligible to enroll through an employer group sponsored Medicare Advantage (MA) health plan or as an individual. You may be newly eligible or able to continue your enrollment under the following circumstances:
   - Individuals with ESRD who age into Medicare can enroll in any MA plan sponsored by their employer or union group regardless of prior commercial coverage affiliation.
   - *If an employer or union group offers an MA plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, ESRD retirees may select this new MA plan option as the employer or union's open enrollment rules allow.*
   - *If an employer or union group that has been offering a variety of coverage options consolidates its employee/retiree offerings (i.e., it drops one or more plans), current enrollees of the dropped plans may be accepted into an MA plan that is offered by the group.*
   - *If an employer or union group has contracted locally with an MA organization in more than one geographic area (for example, in two or more states), an ESRD retiree who relocates permanently from one geographic location to another may remain with the MA organization in the local employer or union MA plan.*
   - Individuals with ESRD who are affected by the contract termination, non-renewal or service area reduction of another Medicare Advantage Organization may make one election to enroll in an MA plan offered by a different Medicare Advantage Organization during the appropriate election period.
   - Once enrolled in an MA plan, an individual with ESRD may elect other MA plans offered by the same MA organization (within the same CMS contract) during an allowable election period. Standard MA eligibility rules apply.

Note: *If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you* ***are not*** *considered to have ESRD and you* ***are*** *eligible to enroll in the MedicareComplete Retiree Plan.*

4. You must permanently reside in the Service Area as defined in Section 14.
5. You must complete and sign an Enrollment Application Form or make an election through your Plan Sponsor. If another person assists you in completing the Enrollment Application Form, that person must also sign the form and state his or her relationship to you.
6. You must agree to abide by the MedicareComplete Retiree Plan rules.

If you meet the above eligibility requirements, you cannot be denied membership in MedicareComplete on the basis of your health status, excluding end-stage renal disease as described above.

When You May Enroll in the MedicareComplete Retiree Plan

Eligible individuals can enroll in the MedicareComplete Retiree Plan at the following times:

- Open Enrollment – You may enroll in the University of California's group plan when that plan is in open enrollment. For more information regarding your open enrollment period, please contact the University of California.

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- Special Election Period (SEP) – Special periods of time in which you can discontinue enrollment in a Medicare Advantage Plan, and change your enrollment to another Medicare Advantage Plan or return to Medicare. In the event of the following circumstances, a Special Election Period is warranted: the Medicare Advantage Plan in which you are enrolled is discontinued in the Service Area in which you live; you move out of the Service Area of the Medicare Advantage Plan; the Medicare Advantage Organization offering the plan violated a material provision of its contract with you; or you meet such other material conditions as CMS may provide.

*As a MedicareComplete Retiree Plan Member, the information below **does not** apply to you because you are allowed to make enrollment changes at times designated by the University of California (see above). Also, please note that your MedicareComplete plan through the University of California does include Medicare Part D prescription drug coverage. However, if you ever choose to discontinue your employer-sponsored health care coverage through the University of California, the information below (up to Creditable Coverage) will apply to you.*

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In general, there are only certain times during the year when you can change the way you get your Medicare coverage. There are also Medicare program limits on how often you can make a change to your Medicare coverage and what types of changes you are allowed to make.

Note: Certain eligible Medicare beneficiaries such as those who are institutionalized, those who receive Medicaid, or those eligible for a Medicare Savings Program such as Medicaid Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual may enroll in MedicareComplete at any time during the Calendar Year.

For Medicare beneficiaries who currently have Medicare coverage, the following dates are important:

From November 15, 2006 through December 31, 2006, anyone with Medicare may change the way they get their Medicare coverage for an effective date of **January 1, 2007.**

Medicare beneficiaries who are enrolled in a Medicare Part D plan and who want to keep their Medicare Part D drug coverage have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in Prescription Drug Plan and return to Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in another Prescription Drug Plan in addition to Original Medicare.

Medicare beneficiaries who are enrolled in a Medicare Part D plan and who do **not** want to keep their Medicare Part D drug coverage have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a “medical only” Medicare Advantage Plan without Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and return to Original Medicare.
- You may leave your current Prescription Drug Plan and continue with Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in a in a “medical only” Medicare Advantage Plan without Medicare Part D drug coverage.

Medicare beneficiaries who are not enrolled in a Medicare Part D plan and who want to enroll in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in a Prescription Drug Plan and return to Original Medicare coverage.

- You may enroll in a Prescription Drug Plan with Original Medicare coverage.
- You may leave Original Medicare and enroll in a Medicare Advantage Plan with Medicare Part D drug coverage.

From January 1, 2007 through March 31, 2007, Medicare beneficiaries (including Members of the MedicareComplete plan) have **one** chance to change the way they get their health care coverage. However, there are limits on when you may change benefit plans and the type of plan that you may join. If you are not enrolled in a plan with Medicare Part D drug coverage, you may not use this time period to enroll in a plan with Medicare Part D drug coverage.

Medicare beneficiaries who are enrolled in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a Prescription Drug Plan and return to Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in a Medicare Advantage Plan with Medicare Part D drug coverage.

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Medicare beneficiaries who are not enrolled in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in another Medicare Advantage Plan without Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and return to Original Medicare.
- If you currently have Original Medicare, you may enroll in a Medicare Advantage Plan without Medicare Part D drug coverage.

Generally, Medicare beneficiaries cannot make any other changes during 2007 unless they meet special exceptions, including but not limited to:

- the Medicare Advantage Plan in which the beneficiary is enrolled is discontinued in the Service Area in which the beneficiary lives
- the beneficiary moves out of the Service Area of the Medicare Advantage Plan
- the beneficiary meets such other material conditions as CMS may provide
- the beneficiary has Medicaid coverage
- the beneficiary receives assistance from a Medicare Savings Program
- the beneficiary is in a long-term care facility such as a nursing home

If you are a Medicare beneficiary who is newly eligible for Medicare coverage:

You may elect to enroll in a Medicare Advantage Plan when you first become entitled to both Part A and Part B of Medicare. Your enrollment period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B, and ends on the last day of the third month after the date on which you become eligible for both Parts of Medicare. For example: if you are eligible for both Part A and Part B on September 1, you may enroll in MedicareComplete as early as June 1, but not later than August 31, for a September 1 Effective Date.

Medicare Part D Late Enrollment Penalty

You will be assessed a penalty by the Federal government when you enroll in Medicare Part D if you did not enroll in a Medicare Part D drug plan during your initial enrollment period and you did not have creditable coverage for a continuous period of 63 days or more after your initial enrollment period. Creditable prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. However, Medicare helps pay for the penalty for individuals who qualify for the most help. People who qualify for the most help will pay 20% of the penalty for the first 60 months and none of the penalty afterwards.

Creditable Coverage

As a MedicareComplete Retiree Plan member, your Plan Sponsor will determine whether or not to offer you a Medicare Part D prescription drug plan. Your MedicareComplete plan through the University of California does include Medicare Part D prescription drug coverage. Medicare Part D prescription drug coverage is considered to be *Creditable Coverage.*

If you purchase a Medicare Part D prescription drug plan on your own, it could result in the loss of your medical coverage provided through the MedicareComplete Retiree Plan and could affect your University of California-sponsored health benefits. It is important to read the communications University of California sends you, and consult with them before you take any action.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You 2007" handbook. You'll get a copy of the handbook in the mail from Medicare. You can also get more information about Medicare prescription drug plans from these places:

- Visit *www.medicare.gov* for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227), (hearing impaired, 1-877-486-2048), 24 hours a day, 7 days a week.

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University of California Eligibility Provisions

Who is Eligible

You may participate in the Plan if you are an eligible Retiree and enrolled in both the Hospital (Part A) and the Medical (Part B) parts of Medicare. The same applies to your Dependents. Dependents who are covered by the PacifiCare plan, but not by both parts of Medicare, may continue in that Plan until they cease to be eligible. Anyone enrolled in a non-University MedicareComplete contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan.

Eligible Retirees (Including Survivors):

You may continue University medical plan coverage when you retire (Retiree) or start collecting disability or survivor benefits (Survivor) from the University of California retirement plan, or any defined benefit plan to which the University contributes, provided:

1. you meet the University's service credit requirements for Retiree medical eligibility;
2. the Effective Date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death in the case of a Survivor);
3. you elect to continue coverage at the time of retirement.

A **Survivor** – a deceased Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan — may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members.*

If you are eligible for Medicare, you must follow UC's Medicare Rules.

The following are the University of California's eligibility criteria for Dependent coverage. In order for Dependents to be enrolled in MedicareComplete, they must also meet the Secure Horizons MA Plan eligibility criteria set forth in this section. Dependents who meet the University of California's eligibility criteria set forth below but do not meet MedicareComplete eligibility criteria may be eligible for coverage through the UnitedHealthcare Health Plan described in Part A of this *Combined Evidence of Coverage and Disclosure Form.*

Eligible Dependents:

SPOUSE: Your legal spouse, except if you are a Survivor you may not enroll your legal spouse.

CHILDREN: Any of your natural or legally adopted children who are unmarried and under age 23. The following children are also eligible: (a) Any unmarried stepchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50 percent of their support and who are your or your spouse's

Dependents for income tax purposes. (b) Any unmarried grandchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50 percent of their support and who are your or your spouse's Dependents for income tax purposes. (c) Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are dependent upon you for at least 50 percent of their support and who are your Dependents for income tax purposes. Your signature on the enrollment form attests to these conditions in (a), (b) and (c) above. You will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent and your signature) to the University to verify income tax dependency. Any unmarried child, as defined above, (except for a child for whom you are the legal guardian) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided the child is dependent on you for at least 50 percent of his or her support; is your Dependent for income tax purposes; the incapacity began before age 23; the child was enrolled in a medical plan before age 23 and coverage is continuous. Application must be made to PacifiCare 31 days prior to the child's 23rd birthday and is subject to approval by the plan. PacifiCare may periodically request proof of continued disability. Your signature on the enrollment form attests to these conditions. You will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependent and your signature) to the University to verify income tax dependency. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required. If the overage handicapped child is not your natural or legally adopted child, the child must reside with you in order for the coverage to be continued past age 23.

Other Eligible Dependents:

You may enroll a same-sex domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll a same-sex domestic partner, contact the University of California's Customer Service Center. Eligible persons may be covered under only one of the following categories: as an Employee, as a Retiree, as a Survivor, or as a Dependent, but not under any combination of these. If both husband and wife are eligible, each may enroll separately or one may cover the other as a Dependent. If they enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's coverage but not under both. The University and/or the Plan reserve the right to periodically request documentation to verify eligibility of Dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the Web site: *http://atyourservice.ucop.edu*.

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University of California Enrollment Provisions

Retirees and their enrolled Dependents who become eligible for Medicare Hospital insurance (Part A) as primary coverage must enroll in and remain in both Hospital (Part A) and Medical (Part B) portions of Medicare.

This includes those who are entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Medicare Parts A and B are then eligible for the Medicare premium applicable to this plan. Retirees or Dependents who are eligible for, but decline to enroll in both parts of Medicare, will be assessed a monthly offset fee by the University to cover the increased costs of remaining in the non-Medicare plan. Retirees or Dependents who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Forms for this purpose may be obtained from the University of California's Customer Service Center at 1-800-888-8267. (Retirees/Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) parts of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

To enroll yourself and any eligible Dependents, you must complete a University of California Medicare Declaration form and MedicareComplete Retiree Election Form. This notifies the University that you are covered by the Hospital (Part A) and Medical (Part B) parts of Medicare. Medicare Declaration forms and MedicareComplete Retiree Election Forms are available through the University of California Customer Service Center and completed forms should be returned to them. Upon receipt by the University of confirmation of Medicare enrollment, the Retiree/Dependent will be changed from the UnitedHealthcare non-Medicare plan to MedicareCompete for Medicare enrollees. Retirees and their Dependents are required to transfer to the plan for Medicare enrollees.

You may also enroll yourself and any eligible Dependents during your Period of Initial Eligibility (PIE) which begins on:

a. the date you have an involuntary loss of other group medical coverage; or

b. the date you move out of a University Health Maintenance Organization (HMO) plan's Service Area on either a permanent basis, or for more than two months on a temporary basis.

If you are a Retiree enrolled as a spouse on a University medical plan and become eligible for both parts of Medicare in your own right, you may enroll yourself on the earlier of:

a. the date both parts of Medicare are in effect; or

b. the Effective Date of retirement.

In addition, you and your eligible Dependents may enroll during a group open enrollment period established by the University.

To enroll your newly eligible Dependents, contact the University of California Customer Service Center to obtain an enrollment form and return it during the Dependent's PIE.

You may enroll Dependents during a newly eligible Dependent's PIE. The PIE starts the day the Dependent becomes eligible for benefits. For a new spouse, eligibility begins on the date of marriage. Survivors may not add new spouses to their coverage.

During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family Members are only eligible for the same plan you are enrolled in.

For a newborn child, eligibility begins on the child's date of birth. For newly adopted children, eligibility begins on the earlier of:

a. the date the Retiree or Retiree's spouse has the legal right to control the child's health care; or

b. the date the child is placed in the Retiree's physical custody.

If not enrolled during the PIE beginning on the date, there is a second PIE beginning on the date that the adoption becomes final.

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You may also enroll your eligible Dependent during a PIE which begins on the date he or she has an involuntary loss of other group medical coverage. Where there is more than one eligibility requirement, enrollment is effective on the date all requirements are satisfied.

A PIE ends 31 days after it begins (or on the preceding business day for the University of California Customer Service Center if the 31st day is on a weekend or a holiday).

If you or your family fail to enroll during the PIE or open enrollment period, you or your dependent may enroll at any other time upon completion of a 90-consecutive calendar-day waiting period. The 90-day waiting period starts on the date the enrollment form is received by the University of California Customer Service Center and ends 90 consecutive calendar days later.

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment before the effective date of retirement (or the date disability or survivor benefits begin).

A Retiree who currently has two or more covered Dependents may add a newly eligible Dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

a. the date the newly added Family Member becomes eligible, or

b. a maximum of 60 days prior to the date his or her enrollment transaction is completed.

Your Enrollment Application Form

Once you complete and sign an Enrollment Application Form, or make an election through the University of California, this information is submitted to CMS for verification of eligibility in MedicareComplete Retiree Plan. If CMS rejects your Enrollment Application Form or election through you Plan Sponsor, we will contact you for additional information or provide you with instructions for resubmitting the Enrollment Application Form or election through your Plan Sponsor.

When Your MedicareComplete Plan Coverage Begins

Effective Date Provisions Coverage for Retirees Enrolling in Conjunction With Retirement

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Coverage for Retirees and their Dependents is effective on the first of the month following the first full calendar month of retirement income, provided the continuation form is submitted to the University of California Customer Service Center.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

Coverage for Retirees or Dependents Becoming Eligible for Medicare

Coverage will be transferred from the UnitedHealthcare plan for non-Medicare enrollees to the MedicareComplete Retiree Plan for Medicare enrollees effective on the date determined by the carrier, based on processing the Election Form through the Centers for Medicare & Medicaid Services (CMS).

Other Situations

Coverage for Retirees and their Dependents enrolling during a PIE is effective on the first day of the PIE provided the enrollment form is received by the University of California Customer Service Center during the PIE. There is one exception to this rule: Coverage for a newly adopted child enrolling during the second PIE is effective on the date the adoption becomes final. For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the University of California Customer Service Center. The Effective Date of coverage for enrollment during an open enrollment period is the date announced by the University. In order to change from individual to two-party coverage and from two-party to family coverage, you will need to obtain a change form from the University of California Customer Service Center, complete and return it.

We will send you a letter that informs you when your coverage begins. From your Effective Date forward, you must receive all routine Covered Services from Contracting Medical Providers. Neither UnitedHealthcare nor Medicare will pay for services received from Non-Contracting Medical Providers, except for:

- Emergency Services anywhere in the world
- Urgently Needed Services that were not foreseeable when you left the Service Area
- Out-of-area renal dialysis services and routine travel dialysis (must be received at a Medicare Certified Dialysis Facility within the United States)
- Referrals that have received Prior Authorization

If you receive any medical services not covered by Medicare before your MedicareComplete plan coverage takes effect, you are financially responsible for those services.

Our Liability Upon Your Initial Enrollment

- We are responsible for the full scope of Part B services, as required by Medicare, beginning on your Effective Date. However, if your Effective Date occurs during an inpatient stay in a Hospital, we are not responsible for arranging or paying for any of the inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A). We must assume responsibility for arranging or paying for inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A) on the day following the day of discharge.

About Your Medicare Supplement (Medigap) Policy

After you receive written confirmation from us of your Effective Date, you may consider canceling any Medicare supplement (Medigap) policy you may have. If you currently have a Medigap policy with prescription drug coverage, you must inform your Medigap issuer you have enrolled in our plan. Medigap policies do not reimburse you for Health Plan Premiums, Copayments, or other amounts that Medicare Advantage Plans charge for Medicare-covered services. However, if you Disenroll from MedicareComplete, you may not be able to have your Medigap policy reinstated and you will not, under any circumstances, be able to have your Medigap policy with prescription drugs reinstated.

- **Note: In certain cases, you may be guaranteed the issue (without medical underwriting or pre-existing condition exclusions) of a Medicare supplemental (Medigap) policy.**

You must apply for a Medigap policy within sixty-three (63) days after your MedicareComplete plan coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, please call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), 24 hours a day, 7 days a week.

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Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive from Non-Contracting Medical Providers. Most supplemental (Medigap) policies will not pay for any portion of such services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an Explanation of Medicare Benefits (EOMB). However, as long as you are a Member of MedicareComplete, Original Medicare will not process any claims for medical services that you receive.
- We have the financial responsibility for all Medicare-covered health services you need as long as you follow MedicareComplete procedures on how to receive medical services.

Some states provide additional Medigap protections. For State specific information, please call Customer Service, your State's Department of Insurance or Health Insurance Counseling & Advocacy Program (HICAP), 1300 National Dr., Suite 200, Sacramento, CA 95834, (916) 419-7500, in-state calls only: 1-800-434-0222, TTY: 1-800-735-2929.

Section 3

MedicareComplete Member Rights and Responsibilities

As a Member, you have the right to receive information about, and make recommendations regarding, your rights and responsibilities

You have the right to:

- Receive information about us and the Covered Services under your plan.
- Submit complaints regarding us or contracting Providers or request appeals for denied service.
- Be treated with dignity and respect and have your right to privacy recognized in accordance with State and federal laws.
- Discuss and actively participate in decision-making with your Contracting Medical Provider regarding the full range of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Refuse any treatment or leave a medical facility, even against the advice of a Contracting Medical Provider. Your refusal in no way limits or otherwise precludes you from receiving other medically necessary covered services for which you consent.
- Complete an Advance Directive, living will or other directive and provide it to your contracting provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an Advance Directive.
- Exercise these rights, regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care.

Your responsibilities are to:

- Review information regarding your benefits, covered services, any Exclusions, limitations, deductibles or Copayments, and the rules you need to follow as stated in your Evidence of Coverage and Disclosure Information and Retiree Benefits Summary.
- Provide us and Contracting Medical Providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your Contracting Medical Provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept your financial responsibility for Health Plan Premiums (if you are responsible to pay your Health Plan Premiums directly to UnitedHealthcare), any other charges owed, and any Copayment or Coinsurance associated with services received while under the care of a contracting provider or while a patient in a facility.

If you have questions or concerns about your rights, please call Customer Service. If you need help with communication, such as help from a language interpreter, Customer Service representatives may assist you. The Medicare program has written a booklet called *Your Medicare Rights and Protections.* To receive a free copy, call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week. Or you may access the Medicare Web site at *www.medicare.gov* to order this booklet or print it directly from your computer.

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Section 4

How Your MedicareComplete Plan Coverage Works

Your MedicareComplete Plan Identification Card

Your MedicareComplete plan identification card provides information to assist you in receiving all your MedicareComplete plan Covered Services. In nearly all instances, you will need to present your plan identification card to your Contracting Medical Provider to verify your coverage and obtain Covered Services.

Carry your MedicareComplete plan identification card with you at all times.

Although you never need to discard your Medicare card, **you must now use your MedicareComplete plan identification card to receive Covered Services.**

It is important for you to use only your MedicareComplete plan identification card — **NOT** your Medicare card — for these reasons:

1. To prevent you from receiving medical services from Non-Contracting Medical Providers in error.
2. In the case of a Medical Emergency, to alert Hospital staff of the need to notify your Primary Care Physician or us as soon as possible so that we are involved in the management of your care.
3. To prevent errors in billing. We pay the bills on behalf of Medicare. Medicare will not pay the bills while you are a Member of MedicareComplete.

If you lose your MedicareComplete plan identification card or change your address, please call Customer Service.

How the Lock-In Feature Works for You and UnitedHealthcare

As a MedicareComplete plan Member, all your medical benefits (except for Emergency Services and Urgently Needed Services and out-of-area renal dialysis and routine travel dialysis and post-stabilization services) are provided or arranged by your Primary Care Physician, a personal physician you choose from the plan's list of Contracting Medical Providers. The day you become a Member of MedicareComplete (your Effective Date), you are **Locked-In** to your Primary Care Physician, who will provide and coordinate all of your routine health care services. Although the MedicareComplete Provider Directory lists many Contracting Providers, once you are Locked-In, you must receive a Referral from your Primary Care Physician or Contracting Medical Group/IPA to receive services from other MedicareComplete Contracting Providers.

You may change your Primary Care Physician by calling Customer Service. (See Section 5 for information on how to change your Primary Care Physician.)

Neither UnitedHealthcare nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a Referral is required, but was not obtained from your Primary Care Physician or Contracting Medical Group/IPA, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis, post-stabilization services, or when you have a Prior Authorization and/or a Referral to a Non-Contracted Provider.

The Lock-In feature is an important part of our contract with CMS, the governmental agency that oversees Medicare. Using the Lock-In feature, we are able to offer Medicare beneficiaries MedicareComplete, with additional benefits that Original Medicare does not offer. Under the CMS contract, the federal government agrees to pay us a fixed monthly dollar amount for each Member. We use the monthly amount received from the federal government to contract with physicians, Hospitals and other health care Providers to arrange care for you.

Neither UnitedHealthcare nor Medicare will pay for services you receive from Non-Contracting Providers outside of this Service Area, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis or post-stabilization services.

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Section 5

Working with Your Contracting Medical Providers

Your Primary Care Physician

As a Member of MedicareComplete, you must select a Primary Care Physician upon enrollment. Your relationship with your Primary Care Physician is an important one because your Primary Care Physician is responsible for the coordination of your health care and can refer you to a Contracting Specialist when necessary.

If you need assistance in choosing your Primary Care Physician, please refer to the Provider Directory for a listing of Primary Care Physicians. For a copy of the most recent Provider Directory, or to seek additional assistance, please call Customer Service, or you may consult the online Provider Directory at: *www.securehorizons.com.*

To promote a smooth transition of your health care when you first join MedicareComplete, please inform us if you are currently seeing a Specialist, receiving Home Health Agency services or using Durable Medical Equipment. Please call Customer Service so that we may assist you with the transfer of care or equipment.

Once you have chosen your Primary Care Physician, we recommend that you have all your medical records transferred to his or her office. This will provide your Primary Care Physician with access to your medical history, and make him or her aware of any existing health conditions you may have.

Always ask to see your Primary Care Physician when you make an appointment. Your Primary Care Physician is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. **When you select a Primary Care Physician, it is important to remember that this limits you to the panel of Specialists** who are affiliated with your Contracting Medical Group/IPA or Network.

Physician-Patient Relationship

You are responsible for selecting a Primary Care Physician. The physician-patient relationship shall be maintained by you and your Primary Care Physician. We are not a health care provider.

We do not prohibit or otherwise restrict a Provider, acting within the lawful scope of practice, from advising, or advocating on your behalf about:

1. Your health status, medical care or treatment options
2. The risk, benefits, and consequences of treatment or non-treatment
3. The opportunity for you to refuse treatment and to express preferences about future treatment decisions

Changing your Primary Care Physician

If you want to change your Primary Care Physician within your Contracting Medical Group/IPA, you must call Customer Service. If

the Primary Care Physician is accepting additional MedicareComplete plan Members, the change will become effective on the first day of the following month. You will receive a new plan identification card that shows this change.

If you want to change to a Primary Care Physician who is affiliated with a different Contracting Medical Group/IPA, you must call Customer Service. If the new Primary Care Physician is accepting additional MedicareComplete plan Members, and your request is received on or before the 15th of the month, the transfer will become effective on the first day of the following month. If your request is received after the 15th of the month, the transfer will become effective the first day of the second month following your request. For example, if we receive your change request on July 15, your change is effective on August 1. If we receive your change request on July 16, your change is effective on September 1. You will receive a new plan identification card that shows this change.

Although we will not deny your request, for continuity of care reasons, it is recommended that you postpone a request to change your Primary Care Physician or Contracting Medical Group/IPA if you are an inpatient in a Hospital, a Skilled Nursing Facility or other medical institution at the time of your request.

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If you change your Primary Care Physician to one who is in a different Contracting Medical Group/IPA or Network, any Referrals to Specialists or Referrals for Covered Services that you previously received may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for a new Referral, which may require further evaluation. In some cases, the request for a new Referral will need to have Prior Authorization from your Contracting Medical Group/IPA or us.

Since your Primary Care Physician is responsible for the coordination of all of your health care needs, it is important that you notify him or her if you wish to continue to receive services or Specialist care from a Provider who is affiliated with your previous Primary Care Physician or Contracting Medical Group/IPA or Network.

If you think that you need to continue to receive ongoing services or Specialist care from the prior Contracting Medical Group/IPA or Network, then for continuity of care reasons, you should discuss this with your Primary Care Physician prior to the determination to transfer to a different Primary Care Physician or Contracting Medical Group/IPA or Network.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, we may authorize continued care.

Continuity of care when you change your Contracting Medical Group/IPA or Network

To promote a smooth transition of your health care when you change your Contracting Medical Group/IPA or Network, please let us know if you are currently seeing a Specialist, receiving Home Health Agency services, or using Durable Medical Equipment. It is important that you contact Customer Service, who will assist you in transferring your care and/or equipment.

If your Primary Care Physician changes to a different Contracting Medical Group/IPA or Network

Sometimes a Primary Care Physician will change to a different Contracting Medical Group/IPA or Network. If you choose to continue care with the Primary Care Physician and change your Contracting Medical Group/IPA or Network, you may need to ask him or her for new Referrals to Specialists for Covered Services, which may require further evaluation. In some cases, this request for a new Referral will need to have Prior Authorization from your Contracting Medical Group/IPA or us.

Because your Primary Care Physician is affiliated with a different group of Specialists, if you think that you need to continue to receive ongoing services or Specialist care from the prior Contracting Medical Group/IPA or Network, then for continuity of care reasons, you should discuss this with your Primary Care Physician. A new authorization may be needed for continued care from the prior Specialist.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, we

may authorize continued care. Please see the heading "Continuity of Care for Members with Terminating Physicians" on a following page of this section for more information.

It is important to remember that your Primary Care Physician selection determines the network of Specialists who are affiliated with your Primary Care Physician's Contracting Medical Group/IPA or Network.

Provider Terminations

It is our policy to give each affected Member timely and consistent notice when his or her Primary Care Physician or Specialist no longer contracts with us or a Contracting Medical Group/IPA. It is our goal to make a good faith effort to notify you within thirty (30) days of the termination of your Primary Care Physician. We will make the same effort to notify you when a Specialist is terminated, and you may be affected. If you choose, we will assist you in selecting a new Primary Care Physician or Contracting Specialist.

We will make a good faith effort to inform you of your right to maintain your treatment with the Specialist through other avenues, which may include joining another Coordinated Care Plan or returning to Medicare.

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How to Schedule an Appointment with Your Primary Care Physician

To schedule an appointment, call your Primary Care Physician's office. There are no special rules to follow. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner. If you have difficulty obtaining an appointment with your Primary Care Physician, please call Customer Service.

The telephone numbers for your Primary Care Physician and/or Contracting Medical Group/IPA or Network are listed on your plan identification card. If you are unable to keep a scheduled appointment, please call your Primary Care Physician twenty-four (24) hours in advance.

How to Receive Care After Hours

If you need to talk to or see your Primary Care Physician after the office has closed for the day, call your Primary Care Physician's office. When the physician on call returns your call, he or she will advise you on how to proceed. See Section 6, Emergency and Urgently Needed Services, for what to do in case of an emergency.

How to Receive Covered Services from a Specialist

Even though your Primary Care Physician is trained to handle the majority of common health care needs, there may be a time when he or she feels you need more specialized treatment. In that case, you may receive a Referral to an appropriate Specialist. In some cases, the request for a Referral will need to have Prior Authorization from us or your Contracting Medical Group/IPA. When you select a Primary Care Physician, it is important to remember this limits you to the network of Specialists who are affiliated with your Primary Care Physician's Contracting Medical Group/IPA or Network.

Neither UnitedHealthcare nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a Referral is required, but was not obtained from your Primary Care Physician or Contracting Medical Group/IPA or us, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis, post-stabilization services, or when you have a Prior Authorization and/or a Referral to a Non-Contracted Provider.

Please refer to the Provider Directory for a listing of MedicareComplete Specialists available through your Network. For a copy of the most recent Provider Directory, or to seek additional assistance, please call Customer Service, or you may consult the online Provider directory at: *www.securehorizons.com.*

Standing Referrals to Specialists

You may receive a standing Referral to a Specialist, if your Primary Care Physician determines, in consultation with the Specialist, your Contracting Medical Group/IPA's Medical Director or one of our Medical Directors that you need continuing care from a Specialist. A "standing Referral" means a Referral by your Primary Care Physician for more than one visit to a Specialist as indicated in the treatment plan without requiring the Primary Care Physician to provide a specific Referral for each visit. The standing Referral will be made according to a treatment plan approved by your Contracting Medical Group/IPA or one of our Medical Directors,

in consultation with your Primary Care Physician, the Specialist, and you, if you have a complex or serious medical condition or a treatment plan is otherwise considered necessary. The treatment plan may limit the number of your visits to the Specialist or may limit the period of time your visits are authorized. The Specialist will provide your Primary Care Physician with regular reports on the health care provided to you. You may request a standing Referral from your Primary Care Physician or a Specialist.

Extended Referral for Coordination of Care by a Specialist

If you have a life-threatening, degenerative, or disabling condition or disease which requires specialized medical care over a prolonged period of time, you may receive a Referral to a Specialist or specialty care center with expertise in treating the condition or disease, for the purpose of having the Specialist coordinate your health care with your Primary Care Physician. To receive an "extended specialty Referral," your Primary Care Physician must determine, in consultation with the Specialist or specialty care center and your Contracting Medical Group/IPA's Medical Director or one of our Medical Directors, that this extended specialized medical care is Medically Necessary. The extended specialty Referral will be made according to a treatment plan approved by your Contracting Medical Group/IPA's Medical Director or one of our Medical Directors, in consultation with your Primary Care Physician, the Specialist and you. After the extended specialty Referral is made, the Specialist will serve as the main coordinator of your care, subject to the approved treatment plan. You may request an extended specialty Referral by asking your Primary Care Physician or Specialist.

Access to OB/GYN Physician Services and Women's Routine and Preventive Health Care Services

You may self-refer to an obstetrical and gynecological (OB/GYN) Specialist within your Contracting Medical Group/IPA or Network for an annual routine Pap smear, pelvic exam and breast exam. You may receive these Covered Services without Prior Authorization or a Referral from your Primary Care Physician. In all cases, however, you must receive Covered Services from an obstetrical and gynecological (OB/GYN) Specialist within your Contracting Medical Group/IPA or Network.

If you visit an OB/GYN or family practice Specialist not affiliated with your Contracting Medical Group/IPA or Network and **without Prior Authorization or a Referral, you will be financially responsible for these services.** Any OB/GYN inpatient or Hospital services, except Emergency or Urgently Needed Services, must be Prior Authorized by your Contracting Medical Group/IPA or Primary Care Physician or us.

To receive OB/GYN Specialist services:

- Select an OB/GYN Specialist within your Contracting Medical Group/IPA or Network. You may select an OB/GYN Specialist from the Provider Directory, visit *www.securehorizons.com* for an on-line directory or call Customer Service for assistance in selecting an OB/GYN within your Contracting Medical Group/IPA or Network. You may also obtain OB/GYN Covered Services from your Primary Care Physician.
- Telephone and schedule an appointment with your selected OB/GYN or Primary Care Physician, if applicable.

Continuity of Care for Members with Terminating Physicians

In the event your Contracting Medical Provider is terminated by us or your Contracting Medical Group/IPA for reasons other than a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from your physician following the termination, providing the terminated physician agrees to the terms and conditions of the contract. Continued care from the terminated physician may be provided for up to ninety (90) days, or a longer period if Medically Necessary, for chronic serious or acute conditions or through the post-partum period for pregnancy related conditions or until your care may safely be transferred to another physician. This does not apply to physicians who have voluntarily terminated their contract with us or a Contracting Medical Group/IPA.

If you are receiving treatment for:

- an acute condition (such as open surgical wounds or recent heart attack)
- serious chronic condition (such as chemotherapy or radiation therapy)

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- a high-risk pregnancy (such as multiple babies, where there is a high likelihood of complications)
- pregnancy in the second or third trimester

and your physician is terminated, you may request to continue receiving treatment from the terminated physician beyond the termination date by calling Customer Service. Your Contracting Medical Group/IPA's Medical Director or one of our Medical Directors in consultation with your terminated physician will determine the best way to manage your ongoing care. **In order for you to continue to receive treatment from the terminated physician, we must provide Prior Authorization of services for continued care.** If you have any questions, or would like a copy of our Continuity of Care Policy, or would like to appeal a denial of your request for continuation of services from your terminated physician, call Customer Service.

Access to Your Medical Records and Files

You have the right to access your medical records and files. We must provide timely access to your records and any information that pertains to them. Please contact your Contracting Medical Provider directly for a copy of your medical records. Except as authorized by federal and State laws, we must obtain written permission from you or your authorized representative before medical records may be made available to any person not directly concerned with your care, or responsible for making payments for the cost of such care.

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Utilization Review

UnitedHealthcare and its Contracting Medical Groups/IPAs use processes to review, approve, modify, delay or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members. This process of Utilization Review (or medical management) is a way to make sure that Members receive the right care, at the right place, by the right Provider.

UnitedHealthcare and its Contracting Medical Groups/IPAs may also use Utilization Review criteria or guidelines to determine whether to approve, modify, delay or deny, based on Medical Necessity, requests by Providers of health care services for Members. The criteria used as the basis of a decision to modify, delay or deny requested health care services in a specific case under review, will be disclosed to the Provider and the Member in that specific case. The criteria or guidelines used to determine whether to authorize, modify, delay or deny health care services are available to the public upon request, limited to the criteria or guidelines for the specific procedure or condition requested.

Decisions to modify, delay or deny requests for authorization of health care services for a Member, based on Medical Necessity, are made only by licensed physicians.

UnitedHealthcare and its Contracting Medical Groups/IPAs make these decisions at least within the timeframes required by federal law or regulation. Please see Section 8 of this Evidence of Coverage and Disclosure Information for specific information regarding the timeframes by which we must make a determination (decision) on your request for payment or the provision of health care services.

If you have general questions regarding Utilization Review and/or would like a copy of our policies and procedures (a description of the processes utilized for authorization, modification, delay or denial of health care services), or our criteria or guidelines, please call Customer Service. If you have specific questions regarding your case, Customer Service will direct you to the appropriate representative who can address issues of approvals or denials of care.

Practitioners and Utilization Review

Utilization Review decision-making is based only on appropriateness of care, service and existence of coverage. While we do compensate practitioners or other individuals conducting utilization review, we do not provide additional compensation to practitioners or other individuals specifically for denying the coverage or services. Financial incentives for Utilization Review decision-makers do not encourage denials of coverage or service.

Second Medical Opinions

You may ask your Primary Care Physician for an authorization for a Second Medical Opinion regarding the advisability of a particular surgery, major nonsurgical procedure or therapeutic procedure. Your request will be evaluated by the Contracting Medical Group/IPA or Network (or one of our Medical Directors) based on Medical

Necessity. In some instances, such as when you receive conflicting First and Second Medical Opinions, you may request an authorization for a Third Medical Opinion from your Primary Care Physician. All decisions regarding Second Medical Opinions will be made within the following time limits: emergency procedures within twenty-four (24) hours; urgent procedures within seventy-two (72) hours and elective procedures within fourteen (14) calendar days.

Second Medical Opinions can only be made by a physician qualified to review the Member's medical condition in question. Referrals to Non-Contracting Medical Providers or Facilities will be approved only when the services requested are not available within the network of Contracting Medical Providers available through your benefit plan. If the Provider giving the Second Medical Opinion recommends a particular treatment, we are not obligated to cover the recommended treatment unless the treatment is determined by us to be Medically Necessary and a Covered Service. If we determine the diagnostic test or service is Medically Necessary and a Covered Service, we or your Contracting Medical Group/IPA may then arrange the treatment, the diagnostic test or service. If you are denied a Second Medical Opinion, you may appeal the denial by following the procedures outlined in Section 8, the Appeals Process.

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We have approved procedures to identify, assess and establish treatment plans (including direct access visits to Specialists) for Members with complex or serious medical conditions. In addition, we will maintain procedures to make sure that Members are informed of health care needs which require follow-up, and receive training in self-care and other measures to promote their own health.

Prior Authorization

Prior Authorization is required for a number of elective treatments, surgeries and drug therapies. The Prior Authorization process is used to make sure the requested procedure is a Covered Service and is necessary and appropriate for the Member's medical situation. The Member's Contracting Medical Group/IPA or our medical personnel evaluate whether or not the Member meets specific predetermined medical criteria, and either approve or deny the requested treatment based upon the assessment. While we or the Member's Contracting Medical Group/IPA, may determine the specific requested treatment is not necessary, and a more appropriate therapy is available, the Member may choose to privately pay for the requested treatment. As a Member, you have the right to file an Expedited Appeal or a Standard Appeal when a Prior Authorization is denied. For further information on how to file an Appeal, please refer to Section 8, Organization Determination, Appeal and Grievance Procedures. Decisions to deny coverage because a treatment is not Medically Necessary are made only by licensed physicians.

If you change your Primary Care Physician to one who is affiliated with a different Contracting Medical Group/IPA or Network, any Prior Authorizations for Covered Services that you received from your previous Contracting Medical Group/IPA or Network, may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for assistance in receiving a new Prior Authorization from us for the requested procedure.

Neither UnitedHealthcare nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a Referral is required, but was not obtained from your Primary Care Physician or Contracting Medical Group/IPA, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis, post-stabilization services, or when you have a Prior Authorization and/or a Referral to a Non-Contracted Provider.

Hospitalization

If your Primary Care Physician or Specialist determines you require hospitalization, Outpatient Services, Home Health Agency Care or Skilled Nursing Care, he or she will arrange these Covered Services for you.

Coverage for Acute Care (referred to in the Member materials as "inpatient Hospital benefits") consists of Medically Necessary inpatient Hospital services authorized by your Contracting Medical Group/IPA or by us, including Hospital room, intensive care, definitive observation, isolation, operating room, recovery room, labor and delivery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and

blood plasma, anesthesia supplies, surgically implanted devices and post-mastectomy implanted breast prosthesis, nursing services, professional charges by the Hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous Hospital charges for Medically Necessary care and treatment.

Coverage for Acute Care and subacute care includes Medically Necessary inpatient services authorized by your Contracting Medical Provider provided in an Acute Care Hospital, a comprehensive, free-standing acute rehabilitation facility or a specially designed unit within a Skilled Nursing Facility.

With the exception of Emergency or Urgently Needed Services, you will only be admitted to those Hospitals, Acute Care and Skilled Nursing Facilities that are Prior Authorized by your Contracting Medical Group/IPA or Contracting Medical Provider and under contract with us. If you are Hospitalized as the result of a Medical Emergency Condition, it is important that you notify your Primary Care Physician or us within forty-eight (48) hours or as soon as reasonably possible, so your Primary Care Physician or we may be involved in the management of your health care. Please contact your Primary Care Physician or us at the number located on your plan identification card (See Section 6 for more information on emergency Hospital admissions.)

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You may call Customer Service to request a copy of our Utilization Review and Prior Authorization processes that apply to care provided in subacute care, transitional inpatient care and Skilled Nursing Facilities.

One of our Medical Directors or designee determines the Hospital or Outpatient Services facility designated by us for elective services. We reserve the right to decline to pay for care for members stable for transfer unless the member is transferred to another facility based upon factors that may include Contracting Medical Provider Hospital privileges, capabilities of the Hospital and outcomes.

Please note: We will not pay federal Hospitals, such as Veteran's Administration (VA) Hospitals, for Emergency and non-emergency items and services furnished to veterans, retired military personnel or eligible dependents. However, we will reimburse Members who are veterans, retired military personnel or eligible dependents for any Copayments or Coinsurance paid to the VA Hospitals for Emergency Services, up to the amount of MedicareComplete Emergency Services Copayment. For Members who are not eligible for VA benefits, we will cover emergency, urgent and post-stabilization care provided by a VA facility; these services are considered out-of-network.

Please refer to the Retiree Benefits Summary for further details.

Hospital Copayments, Coinsurance and Benefit Periods

Depending upon your benefit plan, Inpatient Hospital care Copayments or Coinsurance for each Hospital Stay are charged on either: 1) a per admission basis, or 2) a daily basis for a specified number of days. Once you are discharged from a Hospital, any subsequent Hospital admissions, even for the same medical condition at the same Hospital, will require a Hospital Copayment or Coinsurance. In certain circumstances, you may be discharged from a Hospital and transferred to a Skilled Nursing Care unit or transitional care unit within the same Hospital. If you are later re-admitted to the Hospital from the Skilled Nursing Care unit or transitional care unit, you will pay the Hospital Copayment or Coinsurance. **Original Medicare Hospital Benefit Periods do not apply.** For inpatient Hospital care, you are covered for an unlimited number of days, as long as the Hospital Stay is Medically Necessary and authorized by us or Contracting Medical Providers.

Hospitalist

When you are admitted to a Hospital, a Hospitalist may coordinate your inpatient care. Hospitalists are physicians who are specially trained to care for patients who are acutely ill in the Hospital, and are responsible for coordinating all aspects of your Hospital care. They remain in the Hospital and are available to react should your condition change. This allows your Primary Care Physician or Contracting Medical Provider to continue to see other patients in his or her office while you are Hospitalized. Hospitalists collect and manage all information related to your condition and treatment, and communicate with you, your family and your Primary Care Physician or Contracting Medical Provider throughout your Hospital Stay. Hospitalists work together with your Primary Care Physician or Contracting Medical Provider during

the course of your stay and to transition your care upon discharge. Upon discharge, your Primary Care Physician will again assume coordination of your care.

Skilled Nursing Facility (SNF) Care

MedicareComplete covers Medically Necessary inpatient Skilled Nursing Care and services in a Medicare-certified Skilled Nursing Facility under contract with us. Skilled Nursing Care is covered if the Member requires Skilled Nursing Care services or skilled rehabilitation services on a daily basis, and these skilled services can be provided only on an inpatient basis in a Skilled Nursing Facility. Inpatient stays solely to provide Custodial Care are not covered. Members may not self-refer to a Skilled Nursing Facility. For a list of Skilled Nursing Facility services, please see the Retiree Benefits Summary.

In certain circumstances, Members may be able to receive Skilled Nursing Care from a Skilled Nursing Facility that is not under contract with us. Generally, Members must use Skilled Nursing Facilities contracted with us. However, if certain conditions are met, we may be able to arrange for a Member to receive Skilled Nursing Care from one of the following facilities (“Home Skilled Nursing Facility”): a nursing home or continuing care retirement community where the Member was living prior to the Hospital admission (as long as the facility provides Skilled Nursing Care) or in a Skilled Nursing Facility where the Member’s spouse resides at the time of the Member’s Hospital discharge. In order to access these services, the Skilled Nursing Facility that is not under contract with us must be willing to accept our rates for payment.

Prosthetic Devices, Orthotic Appliances and Durable Medical Equipment and Supplies

Prosthetic devices, orthotic appliances and Durable Medical Equipment (and supplies) are Covered Services according to Medicare coverage guidelines when Medically Necessary. Prosthetic devices aid body functioning or replace a limb or body part. Orthotic appliances are worn or used to correct a defect of body form or function. This includes therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts according to Medicare coverage guidelines.

Repair or replacement of such devices or equipment is covered only when the present device or equipment no longer fulfills its intended function due to: (a) loss, irreparable damage, or excessive wear, except when loss, damage, or excessive wear is due to your fault; or (b) a significant change in your condition. If more than one type of device or equipment can meet your functional needs, only the most cost-effective device or equipment is a Covered Service. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are covered when necessary to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Ambulance

MedicareComplete covers Medically Necessary ambulance services for Emergency or Urgently Needed Services, or when authorized by us or our designee, according to Medicare guidelines. Ambulance services will be provided to the nearest facility with the ability to treat your medical condition. MedicareComplete will not cover ambulance services that are:

1. Member-initiated for social or convenience reasons, not primarily medical in nature, including, but not limited to changing to a different Contracting Medical Group/IPA, moving to be closer to family, and transferring from one nursing facility to another, while an inpatient in an acute, psychiatric or nursing facility.
2. From a contracting facility to another contracting facility, unless the transfer is necessary to deliver medical services authorized by us but not available at the first facility.
3. Air Ambulance services for return to the United States from another country.

Home Health Agency Care Services

If your Primary Care Physician or Specialist determines that you require Home Health Agency care, he or she will arrange these Covered Services for you. In order to qualify for home health benefits, a Member must be confined to his or her home, be under a plan of treatment reviewed and approved by a physician, and require a Medically Necessary qualifying skilled service.

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Covered Home Health Agency services for those who **qualify** may include: part-time or intermittent skilled nursing and home health aide services, physical and occupational therapy and speech-language pathology services, medical social services, medical supplies and Durable Medical Equipment (such as wheelchairs, hospital beds, oxygen and walkers).

When you qualify for coverage of Home Health Agency services, MedicareComplete covers either part-time or intermittent skilled nursing and home health aide services in accordance with Medicare guidelines. Part-time or intermittent means any number of days per week up to twenty-eight (28) hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day, based upon the reasonable need for such care. MedicareComplete may cover, subject to review on a case-by-case basis depending on the need for such care, thirty-five (35) or fewer hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day.

A homebound Member has restricted ability, due to an illness or injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker) or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home, and consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the State, or to attend religious services. Home Health Agency services do not include the costs of housekeepers, food service arrangements or full-time nursing care at home.

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Hospice

Hospice care provides palliative services. Generally, it is based on the philosophy that everyone has the right to spend his or her remaining days in peace and with dignity. Hospice focuses on comfort, dignity and pain control, responding to the symptoms, needs and goals of patients and families. Hospice is dedicated to helping the terminally ill live each day to the fullest throughout the dying process, and supporting them to be with their family and friends in a home setting if they wish.

Hospice care is not a MedicareComplete plan Covered Service. However, we will cover one (1) Hospice evaluation for Members who have not yet chosen Hospice care to determine if Hospice care is an appropriate health care option.

In order to access Hospice care, Members must elect Hospice care under Medicare. Upon making this election, all care related to the terminal illness will be provided by the Medicare-certified Hospice, which is billed directly to Medicare. Any other Medicare covered services that are not related to the terminal illness will also be billed to Medicare. You may remain enrolled in MedicareComplete even if you elect Medicare-certified Hospice coverage for your terminal condition. We will continue to arrange coverage of non-Medicare-covered benefits, to which you are entitled under your MedicareComplete benefit plan, such as routine vision coverage, routine physical exams, and any Optional Supplemental Benefits to which you may be entitled.

As a MedicareComplete plan Member, you have the right to obtain information about all available Medicare-certified Hospice Providers. For more information regarding electing Hospice care, including those Hospice facilities that have an agreement with your Contracting Medical Group/IPA or us, please call Customer Service.

Clinical Trials

A "clinical trial" is a method of testing new types of medical care and treatment. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. **Medical care provided as a part of a clinical trial is not a MedicareComplete plan Covered Service.** Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs such as room and board for a Hospital Stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial. If you

participate in a qualifying clinical trial, you will have to pay Original Medicare Coinsurance for the services you receive. For example, you will be responsible for Part B Coinsurance, usually 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no coinsurance for Medicare-covered clinical laboratory services related to the clinical trial.

When you enroll in a clinical trial, the Providers are paid directly by Medicare for all services you receive that are covered by Medicare. The clinical trial Providers do not have to be Contracting Medical Providers.

You do not need to obtain a Referral or Prior Authorization to join a clinical trial; however, you should inform us before you begin a clinical trial. This allows us to continue to keep track of your health care services. You may remain enrolled in MedicareComplete, even if you do elect to participate in a clinical trial. Your care unrelated to the clinical trial must continue to be arranged by us.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To receive a free copy, call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week, or visit *www.medicare.gov* on the Web.

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Religious Non-medical Health Care Institutions (RNHCIs) Care

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by us under certain conditions. Covered Services in an RNHCI are limited to non-religious aspects of care. To be eligible for Covered Services in an RNHCI, you must have a medical condition that would allow you to receive inpatient Hospital care or extended care services, or care through a Home Health Agency. You may get services when furnished in the home, but only items and services ordinarily furnished by Home Health Agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, State or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from us, or your stay in the RNHCI may not be covered.

Organ Transplants

1. **Organ Transplant Definitions**
   - **Donor:** A person who undergoes a surgical procedure for the purpose of donating either a body organ or body tissue for transplant procedures.
   - **Histocompatibility Testing:** Testing that involves matching or typing of the human leukocyte antigen in preparation for organ or tissue transplant.
   - **UnitedHealthcare United Resource Network facility:** A network of transplant facilities that are: licensed in the State in which they operate, certified by Medicare as a transplant facility for a specific organ transplant, and satisfy our quality of care standards, to be designated by us as a transplant facility for a specific organ program. UnitedHealthcare United Resource Network Facilities may be located outside the Service Area based on a number of factors including quality, cost, and outcomes.
   - **Regional Organ Procurement Agency:** An organization designated by the federal government and responsible for the procurement of organs for transplantation and the promotion of organ donation.

2. **Transplant Services**

   Human organ and tissue transplants are limited to non-experimental/non-investigational procedures that are determined to be Medically Necessary. Coverage is provided for the medical, surgical and Hospital services required for pre-transplant, transplant and post-transplant. All transplant procedures must be performed by approved UnitedHealthcare United Resource Network Facilities. Examples of covered transplant services include:

   - Heart transplants
   - Lung transplants
   - Heart/lung transplants
   - Liver transplants
   - Kidney transplants

- Simultaneous pancreas/kidney transplants
- Pancreas transplant after kidney transplant
- Intestinal and multivisceral transplants
- Cornea transplants (not part of United Resource Network Program)
- Allogeneic bone marrow or stem cell transplant
- Autologous bone marrow or stem cell transplant

We shall intermittently review new developments in medical technology based on scientific evidence to determine if the list of covered transplants should be revised.

Heart transplants including Ventricular Assist Devices (as both "a bridge to transplant," and for "destination therapy") are only covered when the procedure is performed at a UnitedHealthcare United Resource Network Facility or other UnitedHealthcare authorized transplant facilities when determined medically necessary by the UnitedHealthcare United Resource Network Medical Director or designee.

Bone Marrow and Stem Cell Transplants: The testing of immediate blood relatives to determine compatibility of bone marrow and stem cells is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000. An approved UnitedHealthcare United Resource Network facility must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor related clinical transplant services once a donor is identified.

Transportation provided for the Member and one person escort to a facility, if the facility is greater than sixty (60) miles from the Member's primary residence, or out-of-state, regardless of mileage, as Prior Authorized. Food and housing will be provided for the Member and one escort and is limited to $125 per day (excludes liquor and tobacco).

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3. **Organ Procurement, Transplant and Transplant Services**

   Coverage of services shall include:

   - Pre-transplant testing and evaluation, including histocompatibility testing of transplant recipient and non-related or related donor
   - Organ procurement from cadaver or live donor and organ transportation. Covered Services for living donor are limited to Medically Necessary services once a donor is identified
   - Oral or dental examination performed on an inpatient basis as part of comprehensive evaluation work-up prior to transplant procedure
   - When the transplant recipient is a MedicareComplete Member, reasonable and necessary Hospital services of the donor solely for the transplant procedure are covered (the donor does not need to be a MedicareComplete Member)
   - Services and/or charges related to a national donor search
   - Outpatient, post-transplant, immunosuppressive drug therapy (Please see your Retiree Benefits Summary.)
   - Reasonable transportation and lodging for transplant recipient and one person escort determined by transplant facility and/or UnitedHealthcare. Transportation and non-clinical expenses of the living donor are excluded and are the responsibility of the Member, who is the recipient of the transplant.

4. **Prior Authorization**

   Coverage for transplant services must be authorized by us prior to transplant evaluation and prior to listing and services must be performed at a UnitedHealthcare United Resource Network designated facility, which may be located outside the Service Area based on a number of factors including quality, cost and outcomes. New Members, already listed at a non-UnitedHealthcare United Resource Network facility, will be evaluated for continuity of care. UnitedHealthcare requires thirty (30) days to obtain and review relevant clinical information.

Transplant benefits are available only where a facility designated by us is utilized and the Member is a recipient of the transplant.

Please note: We evaluate each transplant case to determine the appropriate transplant facility for each Member. We will select a transplant facility within the United Resource Network based on the medical needs of the Member in consultation with the Member's treating physician and our Transplant Medical Director. Notwithstanding the foregoing, we reserve the right to utilize alternative transplant facilities as authorized by UnitedHealthcare.

5. **Continuity and Coordination of Care**

UnitedHealthcare United Resource Network will continually work closely with the Member, the Member's family, the Member's treating physicians and facilities to monitor the continuity and coordination of services during the pre-transplant evaluation, transplant hospitalization and post-transplant follow-up care. This includes, but is not limited to, reviewing requests from Primary Care Physicians/treating physician for transplant services, facilitating placement on the UnitedHealthcare United Resource Network waiting lists and coordinating post-transplant services.

Following a determination by UnitedHealthcare United Resource Network and the facility that a Member is a candidate for a transplant, the Member will be placed on the transplant waiting list of the UnitedHealthcare United Resource Network facility. For Members who receive transplant services from a UnitedHealthcare United Resource Network facility outside of the Service Area, UnitedHealthcare will work closely with the Member, the UnitedHealthcare United Resource Network facility and the Member's Primary Care Physician/treating physician to coordinate travel to the UnitedHealthcare United Resource Network facility, as appropriate, and at no expense to the Member.

Following transplant and the stabilization of the Member, UnitedHealthcare United Resource Network will coordinate post-transplant services between the UnitedHealthcare United Resource Network Facility and the Member's Primary Care Physician/treating physician. Depending on the UnitedHealthcare United Resource Network facility, the Member may receive post-transplant services locally, or the Member may be required to travel outside of the Service Area. If the Member is required to travel outside the Service Area, UnitedHealthcare will coordinate travel, as appropriate, at no expense to the Member.

6. **Continuity of Care**

Listing of the Member at a second UnitedHealthcare United Resource Network facility is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Member is accepted for listing by both facilities, when associated with continuity of care. If the Member is dual listed, his or her coverage is limited to the actual transplant facility. UnitedHealthcare will collaborate with the Member to determine to which transplant facility he or she should be referred. Duplicated diagnostic costs at a second UnitedHealthcare United Resource Network facility, when the Member has already been evaluated at a UnitedHealthcare United Resource Network facility, will be determined on a case-by-case basis when associated with continuity of care, hardship or when Medically Necessary as defined by UnitedHealthcare transplant policy.

The following services and items are excluded from coverage under the UnitedHealthcare United Resource Network transplant program:

- Unauthorized or not Prior Authorized organ procurement and transplant related services.
- Transplants performed in a non-UnitedHealthcare United Resource Network facility.
- Transplant services, including donor costs, when the transplant recipient is not a Member.
- Artificial or non-human organs.
- Transportation services for any day a Member is not receiving Medically Necessary transplant services.
- Transportation of any potential donor for typing and matching.

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- Food and housing costs for any day a Member is not receiving Medically Necessary transplant services.
- Storage costs for any organ or bone marrow, unless authorized by the UnitedHealthcare Transplant Medical Director.
- Services for which government funding or other insurance coverage is available.

Behavioral Health Services

If you would like to receive a Referral for behavioral health services, please contact your Primary Care Physician or Contracting Medical Group/IPA. Authorized behavioral health services will be provided for a specific number of visits for a specific period of time.

If you change your Primary Care Physician to one who is in a different Contracting Medical Group/IPA, any Referrals for behavioral health services that you previously received may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for a new Referral, which may require further evaluation. In some cases, the request for a new Referral will need to have Prior Authorization from your Contracting Medical Group/IPA or us.

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Since your Primary Care Physician is responsible for the coordination of all of your health care needs, it is important that you notify him or her if you wish to continue to receive behavioral health services from a Provider who was affiliated with your previous Primary Care Physician or Contracting Medical Group/IPA.

If you continue to receive behavioral health services without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, we may authorize continued care. Please see the heading "Continuity of Care for Members with Terminating Physicians" on a previous page of this section for more information.

What happens in an emergency?

In the event of a behavioral health emergency, go to the closest emergency room or call 911. We will cover Emergency Services, whether you are in or out of the Service Area. Ambulance Services dispatched through 911 are only covered if transportation in any other vehicle could endanger your life. Emergency Services are covered whether or not a Contracting Medical Provider provides them. You are strongly encouraged to call your Primary Care Physician or us as soon as possible, preferably within forty-eight (48) hours of a behavioral health medical emergency, so that your Primary Care Physician or we may be involved in the management of your health care. (For more information regarding Emergency and Urgently Needed Services, please see Section 6.)

Note to all MedicareComplete members in following counties or Contracting Medical Groups/IPAs:

- **San Francisco and Sonoma counties**
- **Allcare IPA – Stanislaus County**
- **John Muir/Mt. Diablo Health Network – Contra Costa County**
- **Hill Physicians Medical Group – Alameda, Contra Costa and Sacramento counties**
- **San Jose Medical Group – Santa Clara County**
- **Guardian Medical Associates – San Bernardino County**
- **Physicians Medical Group of Santa Cruz – Santa Cruz County**
- **Sierra Nevada Medical Associates – Nevada County**
- **Sansum-Country Clinic, Sansum-Main Clinic, Sansum-Hollister Branch and Sansum-Jackson Medical Group – Santa Barbara County**

The description of the behavioral health benefit referenced above applies to you. You do not, however, access your behavioral health benefits through your Primary Care Physician or Contracting Medical Group/IPA. You access your behavioral health benefit directly through United Behavioral Health (UBH). To directly access your behavioral health benefits, please call UBH at 1-800-999-9585 (TTY 1-888-877-5378), 24 hours a day, 7 days a week. When you call, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you are experiencing and assess what Provider and treatment would be appropriate for

your situation. If you are Referred to a behavioral health Provider, you will be authorized for a specific number of visits for a specified period of time. You may also call to receive information about contracting practitioners, subspecialty care and obtaining care after normal office hours.

UBH maintains confidentiality to the fullest extent permitted by law so that you may be assured that what you discuss with its staff is kept strictly confidential.

Transgender Benefits

Inpatient Benefits:

Inpatient Transgender Surgery – Inpatient Transgender surgery requires prior authorization from UnitedHealthcare. Transgender surgery and services related to the surgery that are authorized by PacifiCare are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. PacifiCare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Travel expense reimbursement is limited to reasonable expenses for transportation, meals, and lodging for the Member to obtain authorized surgical consultation, transgender reassignment surgical procedure(s) and follow-up care, when the authorized surgeon and facility are located more than 200 miles from the Member's Primary Residence. The transportation and lodging arrangements must be arranged by or approved in advance by UnitedHealthcare. Reimbursement excludes coverage for alcohol and tobacco. Food and lodging expenses are not covered for any day a Member is not receiving authorized transgender reassignment services. Travel expenses are included in the $75,000 lifetime benefit maximum.

Reconstructive Surgery – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Contracting Medical Group/IPA or UnitedHealthcare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery. UnitedHealthcare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery and services related to the surgery require prior authorization by UnitedHealthcare and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Outpatient Benefits:

Outpatient Transgender Services – Outpatient Services including outpatient surgery services for transgender surgery, services related to the surgery, outpatient office visit, and related services, require prior authorization by UnitedHealthcare and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. UnitedHealthcare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

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Exclusions and Limitations

Cosmetic Services and Surgery – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services do not become reconstructive surgery because of a Member's psychological or psychiatric condition. UnitedHealthcare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery and services related to the surgery require prior authorization by UnitedHealthcare and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

No benefits are provided for:

1. Liposuction to reshape waist, hips, thighs and buttocks;
2. Cosmetic chest reconstruction or augmentation mammoplasty;

3. Electrolysis and laser hair removal, except when required as part of covered transgender genital reconstruction surgery;
4. Drugs for hair loss or growth;
5. Voice therapy or voice modification surgery;
6. Sperm or gamete procurement for future infertility or storage of sperm, gametes, or embryos;
7. Penile implant devices, penile device implantation, and penile implant revision or reinsertion;
8. Intersex surgery (transsexual operations) except as specifically provided under the “Limited Transgender Benefit” or treatment of any resulting complications, unless that treatment is determined to be Medically Necessary.

Section 6

Emergency and Urgently Needed Services

You do not need Prior Authorization for the treatment of Medical Emergencies

What is an Emergency Medical Condition?

An Emergency Medical Condition is a medical condition recognizable by symptoms serious enough (including severe pain, serious injury) that a person with an average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in:

1. placing your health at serious risk;
2. serious harm to bodily functions;
3. serious dysfunction of any bodily organ or part.
4. In the case of a pregnant woman, an Emergency Medical Condition exists if the pregnant woman is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is not enough time to safely transfer the pregnant woman to another hospital before delivery; or b) a transfer may pose a threat to the health and safety of the pregnant woman or the unborn child.

Emergency Services are covered for inpatient or outpatient services that are:

1. **provided by a Provider qualified to provide Emergency Services, and**
2. **needed to evaluate or stabilize a Medical Emergency Condition.**

What To Do in an Emergency

In the event of a Medical Emergency, **go to the closest emergency room or call 911** for assistance. We will cover Emergency Services whether you are in or out of the Service Area. Ambulance services dispatched through 911 are only covered if transportation in any other vehicle could endanger your life. You are strongly encouraged to have someone telephone your Primary Care Physician or us at the number listed on your MedicareComplete plan identification card as soon as possible, preferably within forty-eight (48) hours. MedicareComplete offers worldwide emergency coverage.

Emergency Services are covered whether or not a Contracting Medical Provider provides them. It is important to notify your Primary Care Physician or us of a Medical Emergency, so your Primary Care Physician or we may be involved in the management of your health care. If the Medical Emergency requires that you be admitted to an inpatient Hospital, it is important that you notify your Primary Care Physician or us, so a transfer may be arranged when your medical condition is stable (as determined by your treating physician). You are strongly encouraged to have someone telephone your Primary Care Physician or us at the number listed on your MedicareComplete plan identification card as soon as possible, preferably within forty-eight (48) hours.

If you have a Medical Emergency while outside of the Service Area, we will cover your follow-up care outside of the Service Area, if the follow-up care still qualifies as either Emergency or Urgently Needed Care. Follow-up care received out of the Service Area, after treatment for a Medical Emergency that does not qualify as of either Emergency or Urgently Needed Care, is not a Covered Service. If your medical condition no longer requires Emergency or Urgently Needed Care, you must return to your Service Area for follow-up care from your Primary Care Physician. If you receive follow-up care outside of the

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Service Area that does not qualify as Emergency or Urgently Needed Care, you may be financially responsible for the cost of the follow-up care.

You must pay the Emergency or Urgent Care Copayment, whether you receive the Emergency or Urgently Needed Care services in a doctor's office from a physician or a Specialist, or if you receive the Emergency or Urgently Needed Care services in an Urgent Care Facility or a Hospital.

If you have a Medical Emergency within the Service Area, you must contact your Contracting Medical Group/IPA or Primary Care Physician or us as soon as possible, preferably within forty-eight (48) hours after the emergency, so he or she may arrange for your follow-up care.

Post-Stabilization Care

Medically Necessary, non-emergency services following receipt of emergency care to enable you to remain stabilized are covered: when we or our Contracting Medical Providers give Prior Authorization for such services; when we or our Contracting Medical Providers do not respond within one (1) hour to a request for a Prior Authorization from a Non-Contracting Provider or Facility; or when we or our Contracting Medical Providers could not be contacted for Prior Authorization.

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Coverage for post-stabilization care provided by a Non-Contracting Provider continues to be covered until one of the following:

- You are discharged.
- A Contracting Medical Provider arrives and assumes responsibility for your care.
- The Non-Contracting Provider and we agree to other arrangements.
- A Contracting Medical Provider assumes responsibility for your care through the transfer to a contracting facility.

When You Need Urgent Care and You Are Out of Your Service Area

MedicareComplete also covers Urgently Needed Services. Urgently Needed Services are Covered Services provided when you are temporarily* absent from the area served by your Primary Care Physician, Contracting Medical Group/IPA or Network or Contracting Medical Provider (or, under unusual and extraordinary circumstances, you are in the Service Area, but your Contracting Medical Group/IPA or Network or Primary Care Physician is temporarily unavailable or inaccessible), when such services are Medically Necessary and immediately required:

- as a result of an unforeseen illness, injury, or condition, and
- it is not reasonable to obtain the services through your Primary Care Physician or Contracting Medical Provider

* *A temporary absence is an absence from the Service Area lasting not more than six months and it is not a permanent move.*

- If possible, contact your Primary Care Physician or us, then go to a local doctor. If this is not possible, you may go to a Hospital emergency room or other urgent care medical facility.

If you must visit a Provider or a Hospital emergency room for Urgently Needed Services when outside the Service Area, you should contact your Primary Care Physician or Contracting Medical Group/IPA or us as soon as possible, preferably within forty-eight (48) hours so we may be involved in the management of your care. After treatment for out of the Service Area Urgently Needed Care, follow-up care that does not qualify as Urgently Needed Care must be received in the Service Area from your Primary Care Physician. If you receive out of the Service Area follow-up care that does not does not qualify as Urgently Needed Care, you may be financially responsible for the cost of the follow-up care.

Neither UnitedHealthcare nor Medicare will pay for services you receive from Non-Contracting Providers without Prior Authorization outside of this Service Area, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis or post-stabilization services.

When You Need Urgent Care and You Are In Your Service Area

Many Contracting Medical Providers have on-site urgent care centers and many of these centers have extended hours and do not require appointments. We encourage you to take advantage of this convenience in an urgent medical situation.

If you need urgent medical care within your Service Area:

1. Call your Contracting Medical Group/IPA or Primary Care Physician's office at the number listed on your MedicareComplete plan identification card.
2. Identify yourself as a MedicareComplete plan Member, and tell them you feel you need immediate medical attention.
3. Follow any first aid instructions provided (you may be advised to go to your Provider or to a nearby Hospital).

All Contracting Medical Groups/IPAs have a twenty-four (24)-hour emergency number. If, for any reason, you are unable to reach your Contracting Medical Provider, follow the steps for Out-of-Area Urgently Needed Services, as previously described. Follow-up medical care must be received or authorized by your Primary Care Physician or Contracting Medical Group/IPA.

Reimbursement for Services Paid by Member

In most instances, Providers submit bills to us for payment. However, if you paid for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis or post-stabilization services from a Non-Contracting Medical Provider, submit your bills to us for a payment determination. Bills should be submitted to the following address:

UnitedHealthcare Claims Department
P.O. Box 489
Cypress, CA 90630

If you have questions about any bills you receive, call Customer Service.

Right to Appeal

We provide you with a written notice if a service or payment is denied. If we have denied payment for services you think should have been covered, or if we refused to arrange for services that you believe are covered by Medicare, you have the right to appeal. If you think waiting for a decision about authorization for a service could seriously harm your health, you may request an Expedited Appeal. (Please see Section 8.)

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Section 7

Premiums and Payments

As a Member of MedicareComplete, you will be financially responsible for the Health Plan Premiums (if applicable), Copayments and Coinsurance amounts that are listed in the Retiree Benefits Summary.

- **The MedicareComplete Health Plan Premium –** The University of California (Plan Sponsor) is responsible for making payment of the Health Plan Premium, which includes the Medicare Part D premium, directly to UnitedHealthcare on behalf of its enrolled MedicareComplete Retiree Plan Members and their eligible dependent(s). Your Plan Sponsor determines the amount of any retiree subscriber contribution toward Health Plan Premiums.
- **Medicare Part A Premium –** Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Part A). If you are not entitled to Medicare Part A and you have purchased Part A through Social Security, you must continue to pay your Medicare Part A Premium.
- **Medicare Part B Premium –** A monthly premium paid to Medicare to cover Supplemental Medical Insurance (Part B). As a MedicareComplete plan Member, you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is usually automatically deducted from your check. Otherwise, your Premium is paid directly to Medicare by you or someone on your behalf such as Medicaid.
- **Medicare Part D Premium –** A monthly premium paid to Medicare Part D providers, such as UnitedHealthcare to cover Part D prescription drug coverage. Not all MedicareComplete Medicare Advantage benefit plans that offer Medicare Part D prescription drug coverage have a Medicare Part D Premium. The Medicare Part D Premium amount is included in the Health Plan Premium UnitedHealthcare bills to the University of California.

What Happens if You Do Not Pay Your Health Plan Premiums?

If your Plan Sponsor does not pay the Health Plan Premium for the MedicareComplete Retiree Plan, then you will be transferred to an individual MedicareComplete Plan. Once the transfer is effective, you will be responsible for Health Plan Premium payments, if applicable, for an individual MedicareComplete Plan. Monthly Health Plan Premiums and benefits for an individual MedicareComplete Plan vary by the Member's county of residence. If an individual MedicareComplete Plan is not available in the county in which you live, UnitedHealthcare may Disenroll you from the MedicareComplete Retiree Plan. UnitedHealthcare will contact you to inform you of your options.

Until you are notified of your Disenrollment, you will continue to be a MedicareComplete plan Member and must continue to use Contracting Medical Providers. For details on Disenrollment for non-payment of Health Plan Premiums, please see Section 9.

Changes in Health Plan Premiums

Rate changes and University of California-sponsored benefit changes for MedicareComplete Retiree Plan Members are subject to contractual arrangements between UnitedHealthcare and your Plan Sponsor. The plan costs are currently shared between you and the University of California. Your Plan Sponsor is responsible for notifying you of any MedicareComplete Retiree Plan premium changes, contribution changes, or employer-sponsored benefit changes thirty (30) days before they become effective.

Changes in the level of health care coverage may occur at the beginning of each Calendar Year and/or your retiree group contract year. You will receive a written notice at least thirty (30) days prior to the date when such change shall become effective.

Members in some states may be eligible for certain Medigap protections if their MedicareComplete plan has a reduction in benefits or increases in Plan Premiums, Copayments or Coinsurance. For State specific information, please call Customer Service, your State's Department of Insurance or Health Insurance Counseling & Advocacy Program (HICAP), 1300 National Dr., Suite 200, Sacramento, CA 95834, (916) 419-7500, in-state calls only: 1-800-434-0222, TTY 1-800-735-2929.

Section 8

Organization Determination, Medicare Appeal and Grievance Process

As a MedicareComplete plan Member, you are encouraged to let us know if you have concerns or experience any problems with UnitedHealthcare or MedicareComplete. We have representatives available to help with your questions and concerns.

The procedures described in this section may be used if you have an Appeal or Grievance you want us to review. (If your benefit plan includes Medicare Part D prescription drug coverage, please see the Pharmacy Program booklet for Appeal and Grievance information for the Medicare Part D prescription drug benefit.)

Organization Determinations are defined as the decision we make on your request for the provision of services or payment of claims.

Appeals are defined as the type of complaint you make when you want a reconsideration of an Organizational Determination. You may file an Appeal for the following reasons:

- We refuse to cover or pay for services you think we should cover.
- We or one of the Contracting Providers refuses to give you a service you think should be covered.
- We or one of the Contracting Providers reduces or cuts back on services you have been receiving.
- If you think that we are stopping your coverage too soon.

Grievances are defined as the type of complaint you make if you have any other type of problem (other than an Appeal) with us or a Contracting Provider. You would file a Grievance if you have a problem with things such as:

- the quality of your care
- the way MedicareComplete benefits are designed generally
- waiting times for appointments or in the waiting room
- the way your doctors or others behave
- being unable to reach someone by phone or obtain the information you need

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- the lack of cleanliness or condition of the doctor's office.

If either your Appeal or Grievance involves a clinical issue, a medical reviewer who has the education, training and relevant expertise that is pertinent to evaluate the specific clinical issues that serve as the basis of your complaint, will review it.

Organization Determinations

We must make a determination (decision) on your request for the provision of services or payment of claims within the following timeframes:

- **Request for Services or Referrals.** If you request services or require Prior Authorization or a Referral, we must make a decision as expeditiously as your health care requires, but no later than fourteen (14) calendar days after receiving your request for service. An extension up to fourteen (14) calendar days is permitted, if you request the extension, or if we find that additional information is needed that will benefit you (for example, if we need additional medical records from Non-Contracting Providers that could change a denial decision). When we take an extension, you will be notified of the extension in writing.
- **Request for Payment.** If you request payment for services you have already received, we must make a decision on whether or not to pay the claim no later than sixty (60) calendar days from receiving your request.

We must notify you in writing of any organization determination denial decision, (partial or complete) within the timeframes listed above. The notice must state the reasons for the denial, inform you of your right to a standard and expedited reconsideration (Appeal) process and the right to appoint a representative to file an Appeal on your behalf. You also have the right to submit additional information regarding the requested service in writing or in person. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60) calendar days of a request for payment, you may assume the decision is a denial, and you may file an Appeal.

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Expedited/72-Hour Organization Determination Procedures

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize your life or health, or your ability to regain maximum function. If we, or your Primary Care Physician, or Contracting Medical Group/IPA, decide based on medical criteria, that your situation is Time-Sensitive or if any physician calls or writes in support of your request for an expedited review, we, or your Primary Care Physician, or Contracting Medical Group/IPA will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request. We, or your Primary Care Physician, or Contracting Medical Group/IPA may extend this timeframe by up to fourteen (14) calendar days if you request the extension, or if we, or your Primary Care Physician, or Contracting Medical Group/IPA need additional information, and the extension of time benefits you (for example, if we, or your Primary Care Physician, or Contracting Medical Group/IPA need additional medical records from Non-Contracted Providers that could change a denial decision). If the timeframe is extended, you will be notified of the reasons for the delay and informed of your right to file an expedited Grievance should you disagree with an extension. You will be notified promptly of the organization determination, but no later than upon expiration of the extension.

If you believe you need a service and you believe it is a Time-Sensitive situation, you or any physician, including a physician with no connection to UnitedHeatlhcare, may request that the decision be expedited. If we, or your Primary Care Physician, or Contracting Medical Group/IPA decide that it is a Time-Sensitive situation, or if any physician indicates that applying the standard timeframe for making a determination could seriously jeopardize your life, health or your ability to regain maximum function, we, or your Primary Care Physician, or Contracting Medical Group/IPA will make a decision on your request for a service on an expedited/72-hour basis (subject to extension as discussed below).

To request an expedited seventy-two (72) hour organization determination, call us or your Primary Care Physician. **Be sure to ask for an expedited seventy-two (72) hour review when you make your request.**

How Your Expedited/72-Hour Organization Determination Request Will Be Processed

1. Upon receiving your request, we, or your Primary Care Physician, or Contracting Medical Group/IPA will determine if your request meets the definition of Time-Sensitive.
   - If your request does not meet the definition of Time-Sensitive, it will be handled within the standard review timeframe: (fourteen (14) calendar days for organization determinations). You will be informed by telephone that your request for the expedited seventy-two (72) hour review has been denied. You will also be sent a written confirmation that the request will be processed within the standard review timeframe: within three (3) calendar days of the telephone call. If you disagree with our, or your Primary Care Physician's, or Contracting Medical Group's/IPA's decision to process your request within the standard timeframe, you may file an expedited Grievance with us. The written confirmation letter will include instructions on how to file a Grievance. If your request is Time-Sensitive, you will be notified of our, or your Primary Care Physician's, or Contracting Medical Group's/IPA's decision within seventy-two (72) hours. You will also receive a follow-up letter within three (3) calendar days of the phone call.
2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited seventy-two (72) hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life, health, or your ability to regain maximum function.

   If a Non-Contracted Provider supports your request, we, or your Primary Care Physician, or Contracting Medical Group/IPA will have seventy-two (72) hours from the time all the necessary medical information is received from that Provider to make a decision.
3. We, or your Primary Care Physician, or Contracting Medical Group/IPA will make a decision and notify you of it within seventy-two (72) hours of receipt of your request. If we, or your Primary Care Physician, or Contracting Medical Group/IPA do not approve your request, you may appeal to us (see below):

There are four possible dispositions to a request for an expedited organization determination:

- Your request to expedite an organization determination decision is accepted. We, or your Primary Care Physician, or Contracting Medical Group/IPA then make a decision in seventy-two (72) hours and notify you that they will arrange or continue the service.
- Your request to expedite an organization determination decision is accepted. We, or your Primary Care Physician, or Contracting Medical Group/IPA then make a decision in seventy-two (72) hours and notify you that they will **not** arrange or continue the service, and you may appeal to us.
- Your request to expedite the organization determination is **not** accepted. We, or your Primary Care Physician or Contracting Medical Group/IPA then inform you that your request will be handled under the standard organization determination process.
- Your request to expedite an organization determination cannot be made in seventy-two (72) hours, we, or your Primary Care Physician, or Contracting Medical Group/IPA then inform you that they will need up to an additional fourteen (14) calendar days to process your request.

If you have questions regarding these rights, please call Customer Service.

General Information on the Medicare Appeal Process

As a MedicareComplete plan Member, you have the right to appeal any organization determination about our payment for, or failure to arrange or continue to arrange for, what you believe are Covered Services (including Optional Supplemental Benefits) under your Medicare Advantage Plan. These include:

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- Payment for out-of-area renal dialysis and routine travel dialysis services, Emergency Services, Post-Stabilization Care or Urgently Needed Services
- Payment for any other health services furnished by a Non-Contracted Provider or Facility you believe are covered under Original Medicare or should have been arranged for, or reimbursed by us
- Services you have not received, but you believe are our responsibility to pay for or arrange
- Discontinuation of services you believe are Medically Necessary Covered Services
- Our failure to approve, furnish, arrange for, or provide payment for, health care services in a timely manner, or to provide you with a timely notice of an adverse determination, such that a delay would adversely affect your health

Use the Appeal procedure when you want a reconsideration of a decision (organization determination) that was made regarding a service or the amount of payment we paid for a service.

Use the Grievance procedure for any complaints or other disputes that are not denied claims or denied services subject to organization determination as explained above. If you have a question about which complaint process to use, please call Customer Service.

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We are required to track all Appeals and Grievances in order to report cumulative data to CMS and to MedicareComplete plan Members upon request.

Who May File an Appeal

1. You may file an Appeal.
2. Someone else may file the Appeal for you on your behalf. You may appoint an individual to act as your representative to file the Appeal for you by following the steps below:

   a. Provide us with your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: you may appoint a physician or a Provider.) For example: "I *[your name]* appoint *[name of representative]* to act as my representative in requesting an Appeal from UnitedHealthcare and/or CMS regarding the denial or discontinuation of medical services. My Medicare number is *[your Medicare number]*."

   b. You must sign and date the statement.

   c. Your representative must also sign and date this statement.

   d. You must include this signed statement with your Appeal.
3. A Non-Contracted Provider may file a standard Appeal of a denied claim if he or she completes a waiver of payment statement, which says he or she will not bill you regardless of the outcome of the Appeal.

Support for Your Appeal

You are not required to submit additional information to support your request for reconsideration (Appeal). We are responsible for gathering all necessary medical information. However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include information in your Appeal request, such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Physician. If your medical records from a Specialist are not included in your medical records from your Primary Care Physician, you may need to submit a separate request to the Specialist who provided medical services to you.

Assistance with an Appeal

Regardless of whether you request a standard or expedited Appeal, you may have a friend, lawyer or someone else help you. There are lawyers who do not charge unless you win your Appeal. Groups, such as lawyer referral services, may help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

Standard Appeal Procedures

If you decide to proceed with the Medicare Standard Appeal Procedure, the following steps will occur:

You must submit a written request for a reconsideration to our Appeals and Grievance Unit at P.O. Box 6006, Cypress, CA 90630, Mailstop: CA124-0157. You may also request a reconsideration through the Social Security

Administration Office. You may contact the Social Security Administration Office at 1-800-772-1213 toll-free, (TTY 1-800-325-0778 toll-free). You also may visit the Social Security Web site at *www.ssa.gov.*

1. You must submit your written request within sixty (60) calendar days of the date of the notice of the initial organization determination.

   Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day timeframe.

2. We will conduct a reconsideration and notify you in writing of the decision within thirty (30) days, if the Appeal is for a request for a denied service. Note that we must notify you of the reconsideration decision as expeditiously as possible, but no later than thirty (30) calendar days from receipt of your request. We may extend this timeframe by up to fourteen (14) calendar days, if you request the extension, or if we find that additional information is needed and the extension of time benefits you (for example, if we need additional medical records from Non-Contracted Providers that could change a denial decision).

   If the Appeal is for a denied claim, we must notify you of the reconsideration determination no later than sixty (60) days after receiving your request for a reconsideration determination.

   Our reconsideration decision will be made by a person(s) not involved in the initial decision. A physician with expertise in the field of medicine that is appropriate for the service at issue must make all reconsiderations of adverse organization determination based on Medical Necessity. However, that physician need not be of the same specialty or subspecialty as the treating physician.

3. If we decide to reverse the original adverse decision, we must authorize or arrange your service as expeditiously as your health requires, but no later than thirty (30) calendar days from the date we received your request for an Appeal; or we will pay your claim within sixty (60) calendar days of your request for an Appeal.

4. If we decide to uphold the original adverse decision, either in whole or in part, or if we fail to provide a decision on your reconsideration within the relevant timeframe, we will automatically forward the case to an Independent Review Entity for a new and impartial review, and you will be notified. We must send the file to the Independent Review Entity within thirty (30) days of a request for services and within sixty (60) days of a request for payment. The Independent Review Entity will either uphold our decision or issue a new decision. If we forward the case to the Independent Review Entity, we still must notify you of the decision within the relevant timeframe discussed above.

5. For cases submitted to an Independent Review Entity for review, the Independent Review Entity will make a reconsideration decision and notify you in writing of its decision and the reasons for the decision. **If the Independent Review Entity decides in your favor and reverses our decision, the following must occur:**

   Request for Service: If the Independent Review Entity decides in your favor, we must authorize the service under dispute within seventy-two (72) hours from the date of receipt of the Independent Review Entity's notice reversing our decision, or provide the service under dispute as expeditiously as your health condition requires, but no later than fourteen (14) calendar days from date of receipt of the Independent Review Entity's notice.

   Request for Payment: If the Independent Review Entity decides in your favor, we must pay for the service no later than thirty (30) calendar days from the date of the Independent Review Entity's notice. If the Independent Review Entity maintains our decision, its notice will inform you of your right to a hearing before an Administrative Law Judge (ALJ) of the Office of Medicare Hearings and Appeals.

6. You may request a hearing before an Administrative Law Judge by submitting a written request to us, CMS or the Social Security Administration Office within sixty (60) days of the date of the Independent Review Entity's notice that the reconsideration decision was not in your favor. This sixty (60) day notice may be extended for good cause. A hearing can be held only if the amount in

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controversy meets the dollar requirement ($110 or more). The Administrative Law Judge will not review your appeal if the dollar value of the contested benefit does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. All hearing requests will be forwarded to the Independent Review Entity. The Independent Review Entity will then forward your request and your reconsideration file to the hearing office. We will also be made a party to the Appeal at the ALJ level.

7. If the Administrative Law Judge's decision is adverse, either you or we may request a review by the Medicare Appeals Council of the Social Security Administration Office, which may either review the decision or decline review. If the Administrative Law Judge decides in your favor, we must pay for, authorize or provide the service you have asked for within sixty (60) calendar days from the date we receive notice of the decision. However, if we appeal this decision by asking for a review by the Medicare Appeals Council, we may await the Medicare Appeals Council's decision before complying with the decision of the ALJ.

8. If the dollar value of your contested medical care meets the dollar requirement, ($1,130 or more), either you or we may request that a decision made by the Medicare Appeals Council or the Administrative Law Judge, or if the Medicare Appeals Council has declined review, be reviewed by a federal district court.

9. Any initial or reconsidered decision made by us, an Independent Review Entity, the Administrative Law Judge or the Medicare Appeals Council can be reopened: (a) within twelve (12) months; (b) within four (4) years for just cause; or (c) at any time for clerical correction or in cases of fraud.

10. Independent Review Entity Re-openings: A reopening is not an Appeal right. Any of the parties to a reconsideration determination may request a reopening; however, granting a reopening is solely at the Independent Review Entity's discretion. The party requesting a reopening must clearly state in writing the basis on which the request is made. All Independent Review Entity determinations advise the parties of the standards for reopening of the case by the Independent Review Entity. Any party to the determination may request a reopening, if the party believes one of the following grounds for reopening is applicable:

    - Error on the face of the evidence by the Independent Review Entity in its review
    - Fraud
    - New and additional information that was not available at the time the Independent Review Entity made its initial determination in the case

    A Medicare Advantage Organization's request for a reopening does not relieve the Medicare Advantage Organization of the responsibility to comply with the Independent Review Entity's decision within the required timeframes. However, if the Independent Review Entity's decision at the conclusion of the reopening review is unfavorable to you, you will be liable for the cost of the care rendered.

11. The reconsidered determination is final and binding upon us. Binding arbitration does not apply to disputes subject to CMS's appeals process.

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Expedited/72-Hour Appeal Procedures

You have the right to request and receive an expedited seventy-two (72)-hour reconsideration (Appeal), in situations where waiting for a reconsideration (Appeal) decision to be made within the standard timeframe could seriously jeopardize your life, health or your ability to regain maximum function. If we decide, based on medical criteria, that your situation is Time-Sensitive or if any physician calls or writes in support of your request for an expedited reconsideration (Appeal) review, we will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request. We may extend this timeframe by up to fourteen (14) days if you request the extension or if we need additional information, and the extension of time benefits you (for example, if we need additional medical records from Non-Contracted Providers that could change a denial decision). If the reconsideration (Appeal) timeframe is extended, you will be notified of the

reasons for the delay and informed of your right to file an expedited Grievance should you disagree with an extension. You will be notified promptly of our determination, but no later than upon expiration of the extension.

If you wish to request a reconsideration (Appeal) of a decision by us to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service, and you believe it is a Time-Sensitive situation, you or your authorized representative may request that the reconsideration (Appeal) be expedited. If a physician wishes to file an expedited Appeal for you, you must give him or her authorization to act on your behalf. If we or any physician decides that it is a Time-Sensitive situation, we will make a decision on your Appeal on an expedited seventy-two (72)-hour basis. Examples of service decisions which you may appeal on an expedited basis, when you believe it is a Time-Sensitive situation, include the following:

- If you received a denial of a service you requested
- If you think you are being discharged from any of the following too soon and you have missed the deadline for a Quality Improvement Organization (QIO) review:
  - Hospital
  - Skilled Nursing Facility (SNF)
  - Home Health Agency (HHA)
  - Comprehensive Outpatient Rehabilitation Facility (CORF)

The procedures for requesting and receiving an expedited Appeal are described in the following sections.

How to Request an Expedited Reconsideration

To request an expedited seventy-two (72)-hour review, you or your authorized representative may call, write, fax or visit us. **Be sure to ask for an expedited seventy-two (72)-hour review when you make your request.**

Call: 1-866-622-8055
8:00 a.m. to 8:00 p.m.
7 days a week
We will document your request in writing.

TTY: 1-888-685-8480
8:00 a.m. to 8:00 p.m.
7 days a week
We will document your request in writing.

Write: UnitedHealthcare Appeals and Grievance Unit
P.O. Box 6006
Cypress, CA 90630
Mailstop: CA124-0157

Fax: 1-800-346-0930
Attention: Appeals and Grievance Unit

Walk in: UnitedHealthcare Customer Service Center
6200 Northwest Parkway
San Antonio, TX 78249-3348
8 a.m. to 5 p.m. CST
Monday through Friday

Note: The Appeals and Grievance Unit will record the date and time of all telephone or fax requests for expedited seventy-two (72)-hour reviews received before or after business hours, Monday through Friday, or on Saturday or Sunday. The seventy-two (72)-hour period for the expedited review will begin at the time received.

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How Your Expedited/72-Hour Reconsideration Request Will Be Processed

1. Upon receiving your reconsideration request, we will determine if your request meets the definition of Time-Sensitive.
   - If your request does not meet the definition, it will be handled within the standard review process (thirty (30) days for pre-service and sixty (60) days for a claim). You will be informed by telephone that your request for the expedited seventy-two (72)-hour Appeal review has been denied. You will be sent a written confirmation that the request will be processed within the standard review timeframe: within three (3) calendar days of the telephone call. If you disagree with our decision to process your request within the standard timeframe, you may file a Grievance with us. The written confirmation letter will include instructions on how to file an expedited Grievance.

- If your request is Time-Sensitive, you will be notified of our Appeal decision within seventy-two (72) hours. You will also be sent a follow-up decision letter within three (3) calendar days of the telephone call.
- An extension up to fourteen (14) calendar days is permitted for a seventy-two (72)-hour Appeal if the extension of time benefits you, for example, if you need time to provide us with additional information, or if we need to have additional diagnostic testing completed. We will make a decision as expeditiously as your health requires, but no later than the end of any extension period. If the timeframe is extended, you will be notified of the reasons for the delay and informed of your right to file an expedited Grievance should you disagree with an extension.

2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited seventy-two (72)-hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life or health or your ability to regain maximum function.

   If a Non-Contracted Provider supports your request, we may request a fourteen (14) day extension if obtaining necessary medical information from the Provider will benefit you.

3. We will make a decision on the Appeal and notify you of it within seventy-two (72) hours of receipt of your request. If we decide to uphold the original adverse determination, either in whole or in part, we will forward the entire file to the Independent Review Entity for review no later than twenty-four (24) hours after our decision. The Independent Review Entity will send you a letter with their decision within seventy-two (72) hours of receipt of your case from us, or at the end of the fourteen (14) day extension.

There are four possible dispositions to a request for expedited Appeals:

- Your request to expedite an Appeal decision is accepted. We then make a decision in seventy-two (72) hours and notify you that the care will be arranged or continued.
- Your request to expedite an Appeal decision is accepted. We then make a decision in seventy-two (72) hours and notify you that the care will not be arranged or continued and the case will be sent to the Independent Review Entity for determination within twenty-four (24) hours.
- Your request to expedite an Appeal decision is **not** accepted. We then inform you that your request will be handled under the standard Appeal process.
- Your request to expedite an Appeal decision cannot be made in seventy-two (72) hours. We then inform you that we will need up to an additional fourteen (14) calendar days to process your request.

If you have questions regarding these rights, please call Customer Service.

Information You Should Receive During Your Hospital Stay

When you are admitted to the Hospital, someone at the Hospital should give you a notice called the *Important Message from Medicare*. This notice explains your rights under the law. When a doctor decides that you are ready to leave the Hospital (to "be discharged"), and if you believe you should not be discharged yet, you should be given a copy of another notice that includes specific information about your Hospital discharge. This other notice is called the *Notice of Discharge and Medicare Appeal Rights*. It will tell you:

- Why you are being discharged.
- The date that we will stop covering your Hospital Stay (stop paying our share of your Hospital costs).
- What you can do if you think you are being discharged too soon.
- Whom to contact for help.

As a Member, you should receive this information about your discharge before you leave the Hospital. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the Hospital — it only means that you received the notice. If you do not receive the notice after you have told the Hospital that you

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think you are being discharged too soon, ask for the *Notice of Discharge and Medicare Appeal Rights* immediately.

Quality Improvement Review

If you are in the Hospital and you think that you are being discharged too soon, you have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge and Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization (QIO) to review whether your discharge is medically appropriate.

The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of UnitedHealthcare or your Hospital. There is one QIO in each State. QIOs have different names, depending on which State they are in. The phone number and address of the QIO for your area is:

Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104
(415) 677-2000
1-800-841-1602
TTY: 1-800-735-2922

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The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their Hospital Stay is ending too soon.

Getting a QIO Review of Your Hospital Discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge and Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for an expedited seventy-two (72)-hour review of whether you are ready to leave the Hospital.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the Hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the Hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the Hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your Hospital Stay for as long as Medically Necessary.

What if You Do Not Ask the QIO for a Review by the Deadline?

You may have to pay, if you stay past your discharge date.

If you do not ask the QIO by noon of the next working day after you are given written notice that you are being discharged from the Hospital, and if you stay in the Hospital after this date, you run the risk of having to pay for the Hospital care you receive on and after this date. However, you may appeal any bills for Hospital care you receive as described above.

Another Option: Asking for an Expedited/72-Hour Review of Your Discharge

If you do not ask the QIO to do an expedited seventy-two (72)-hour review of your discharge, you may ask us for an expedited seventy-two (72)-hour review of your discharge. This is described above. If you ask us for an expedited seventy-two (72)-hour review of your discharge and you stay in the Hospital past your discharge date, you run the risk of having to pay for the Hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the expedited seventy-two (72)-hour review, that you need to stay in the Hospital, we will continue to cover your Hospital care for as long as Medically Necessary.

- If we decide that you should not have stayed in the Hospital beyond your discharge date, then we will **not** cover any Hospital care you received if you stayed in the Hospital after the discharge date. If we determine that the Member should not have stayed in the hospital past the proposed discharge date, the case will be forwarded to the IRE for a final determination.

Termination of Services in Certain Provider Settings (Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF))

When coverage for a Prior Authorized course of treatment ends in a SNF, HHA or CORF, you should receive advance written notification of the termination of services that includes your Appeal rights and the date on which coverage of the service ends. This notice is called the *Notice of Medicare Non-Coverage*. You must receive the notice no later than two (2) days prior to the termination (or at the time of admission if your stay is expected to be less than two (2) days). You (or someone you authorize) will be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the SNF, HHA or CORF; it only means that you received the notice. If you do not receive the notice when you are being told about the termination of services, ask for it immediately.

Review of Termination of SNF, HHA or CORF Services by the QIO

If you think coverage of your services in a SNF, HHA or CORF is being terminated too soon, you have the right by law to request a "fast-track" Appeal by contacting the QIO in writing or by telephone:

- If you get this notice two (2) days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get this notice and you have more than two (2) days before your coverage ends, then you must make your request **no later than noon** the day before the date that your coverage ends. The QIO will notify us that you are appealing the termination, and we will issue a *Detailed Explanation of Non-Coverage* to both you and the QIO.

The QIO will review your medical information, then give an opinion about whether it is medically appropriate that your services are being terminated. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that the termination of services was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you received from us. Neither Original Medicare nor we will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability. You may request a reconsideration by the QIO, but you will be liable for any services received following the date on which you receive the QIO's initial decision. **Note: Decisions made by the QIO are not appealable through us.**
- If the QIO agrees with you, we will continue your services for only as long as is Medically Necessary, or based on Medicare coverage limitations.

Asking for an Expedited/72-Hour Review of Your Termination of Services

You may appeal the termination of SNF, HHA or CORF services under the Expedited (72-Hour) Appeal Process described earlier in this section, only if you miss the deadline for a fast-track Appeal through the QIO.

If you ask us for an expedited Appeal of your termination, and you continue to receive services from the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care that you receive on or after this date. However, you may appeal any bills for SNF, HHA or CORF care you receive using the standard appeal process described earlier in this section.

Grievance Procedures

Informal Complaints

We will attempt to resolve any complaint (Grievance) you might have. We encourage the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. If you have a complaint, please call Customer Service. A more formal Member

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Grievance procedure is available, if your complaint cannot be resolved in this manner.

Formal Complaints

As a MedicareComplete plan Member, you have the right to file a complaint, also called a Grievance, about problems you observe or experience, including:

- Complaints about the quality of services that you receive or delays in providing care
- Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns
- General complaints about increases in Member liability or benefit design
- Involuntary Disenrollment situations (See Section 9)
- If you disagree with our decision to extend the timeframe on a standard or expedited request
- If you disagree with our decision to extend the timeframe on a standard or expedited Appeal
- If you disagree with our decision to process your organization determination request for service under the standard fourteen (14) day timeframe, rather than the expedited seventy-two (72)-hour timeframe
- If you disagree with our decision to process your reconsideration (Appeal) request under the standard thirty (30) day timeframe rather than the expedited seventy-two (72)-hour timeframe.

To use the formal Grievance procedure, submit your Grievance in writing to our Appeals and Grievances Unit.

However, complaints about a decision regarding payment or provision of Covered Services that you believe are covered by Medicare and should be arranged or paid for by us, must be appealed through the Medicare Appeals Process. (See above.)

Complaints That Do Not Relate to Quality of Medical Care Issues

We review complaints that do not relate to quality of medical care issues in consultation with our appropriate departments. We will write you to acknowledge your complaint and let you know how we have addressed your concern within thirty (30) days of receiving your written Grievance. If you request an expedited grievance related to our decision to invoke an extension on your request for an organization determination or reconsideration, or our decision to process your expedited request as a standard request, we will acknowledge your grievance within twenty-four (24) hours of receipt and notify you in writing of our conclusion within three (3) calendar days. In some instances, we will need additional time to address your concern. If additional time is needed, we will keep you informed regarding the status of your Grievance.

Complaints Involving Quality of Medical Care Issues

All complaints that involve quality of medical care issues are referred to our Health Services Department for review. Complaints that affect a Member's immediate condition will receive immediate review. We will investigate the complaint, consulting with your Contracting Medical Group and our appropriate departments, and reviewing medical records as necessary. You may need to sign an authorization to release your medical records. We will confirm receipt of your complaint within thirty (30) days of receiving your complaint, whenever possible. The results of the Quality Management review are confidential.

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QIO Quality of Care Complaint Process

If you are concerned about the quality of care you have received, you may also file a complaint with the QIO in your local area. (For the name, address and telephone number of your local QIO, please see the Quality Improvement Review portion of Section 8.)

Binding Arbitration

The parties voluntarily agree that, as to any and all disputes between enrollee (including any heirs and anyone you assign your rights to) and the Plan (including any of its parents, subsidiaries or affiliates; "UnitedHealthcare") (collectively, the "Parties"), that the binding arbitration provision below will be used to resolve any disputes that are not subject to the Medicare appeals process, or any other administrative appeals process ("Arbitration Claims"), as found in Section 8 of this Evidence of Coverage agreement, and that are not otherwise governed by federal law, as nothing in this Arbitration provision alters the Parties' rights to the Medicare Appeals Process.

THE PARTIES VOLUNTARILY AGREE TO SUBMIT ALL CLAIMS TO THE MEDICARE APPEALS PROCESS, AND TO EXHAUST THAT APPEALS PROCESS AS WELL AS ANY OTHER ADMINISTRATIVE APPEALS PROCESS ("COLLECTIVELY, THE "ADMINISTRATIVE APPEALS PROCESSES"). THE PARTIES UNDERSTAND THAT ALL DISPUTES DEEMED TO BE OUTSIDE THE SCOPE OF ANY ADMINISTRATIVE APPEALS PROCESSES WILL BE DECIDED BY BINDING ARBITRATION, INCLUDING MEDICAL MALPRACTICE DISPUTES (THAT IS, WHETHER ANY MEDICAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED). THE PARTIES UNDERSTAND THAT THEY ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL FOR THOSE CLAIMS THAT ARE REQUIRED TO GO TO ARBITRATION UNDER THIS PROVISION. FURTHER, THE PARTIES UNDERSTAND THEY ARE GIVING UP THEIR RIGHT TO HAVE ANY DISPUTES RESOLVED BY COURT PROCESS WITH TWO EXCEPTIONS: A FEDERAL COURT APPEAL CHALLENGING ANY ADMINISTRATIVE APPEALS PROCESSES' DECISION AND THE JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS.

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Any Party seeking arbitration must serve a demand for arbitration within one (1) year of a final decision of any Administrative Appeals Processes, or within one (1) year after the circumstances that gave rise to the Arbitration Claims, whichever is greater, or lose their right to pursue their Arbitration Claims in any forum.

The Parties shall try to agree on a single arbitrator within thirty (30) days after either party demands an arbitration, but if they cannot agree on an arbitrator within that time one will be appointed for them using the procedures in the Comprehensive Rules and Procedures of JAMS (the "Rules"), whose rules can be found at *www.jamsadr.com*. The arbitration shall be carried out according to the JAMS Rules, except as set forth below, and the arbitrator shall not apply any other rules or procedures unless the Parties agree in writing.

The parties also agree that no claim submitted to arbitration may be brought as a class action, representative action, or as a private attorney general action. You agree that you will not represent a class or participate as a member of a class in any Arbitration Claims. The Parties agree that any decision relating to class-related issues, including the certification of a class, the availability of class claims, and the validity and effect of this class prohibition, shall only be made by a court of competent jurisdiction. A court may sever any portion of Section 9 that it finds unenforceable except for this prohibition on class actions, representative actions or private attorney general actions for claims submitted to arbitration. If this class-prohibition clause is found to be unenforceable the entire arbitration agreement shall not be enforceable and the Parties may only resolve their claims in a court of competent jurisdiction.

The arbitration proceedings shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, and be held either in the county where you live, or at another location the Parties agree to in writing. To the extent that any arbitration proceeding is not governed by federal law, this arbitration agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware. The arbitrator may not award punitive, exemplary, indirect or special damages, except with statutory claims that explicitly provide for those forms of relief. The decision of the arbitrator will be final and binding on both Parties, and judgment on an award may be entered by any court of competent jurisdiction. The arbitrator will provide the Parties with the reasoning behind the award in a written legal opinion that applies the law to the facts of the case. All aspects of any arbitration brought in accordance with the terms of this agreement shall remain strictly confidential.

The Parties shall divide equally the expense of the arbitration, including the arbitrator's fees, and each Party shall be responsible for their own attorneys' fees, unless otherwise required by federal or State statute. In cases of hardship, we shall pay all or part of your share of the expenses and fees of the arbitrator, if you submit a hardship application to the arbitrator and the arbitrator approves the application.

From **November 15, 2006 through December 31, 2006,** you may Disenroll from MedicareComplete and choose another health plan or return to Original Medicare for a January 1, 2007 effective date. During this same time period, all Medicare beneficiaries may make a change to the way they get their Medicare coverage by choosing to enroll in a plan which offers Medicare Part D drug coverage or Disenrolling from a plan which offers Medicare Part D drug coverage.

From **January 1, 2007 through March 31, 2007,** you may choose to end your membership in MedicareComplete for any reason. However, there are Medicare program limits on the types of changes you are allowed to make. If on January 1, 2007, you are enrolled in a MedicareComplete plan without Medicare Part D drug coverage, you may **not** use this time period to enroll in a Medicare Part D drug plan. Also, if on January 1, 2007, you are enrolled in a MedicareComplete plan with Medicare Part D drug coverage, you may **not** use this time period to Disenroll from a Medicare Part D drug plan.

Generally, after **March 31, 2007,** you cannot Disenroll from MedicareComplete unless you qualify for a special exception such as moving out of the Service Area or if you have Medicaid. (For more information on enrollment rules, see Section 2).

If you wish to Disenroll from any MedicareComplete plan between November 15, 2006 and December 31, 2006:

- You or your authorized representative may request Disenrollment directly from us. In order to proceed with your Disenrollment request, you must send a written, signed and dated letter or fax to us. If you have any questions about the letter, please contact Customer Service.
- You or your authorized representative may call the national Medicare help line at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week to Disenroll over the phone.
- You may switch to another Medicare Advantage Plan with Medicare Part D drug coverage by simply enrolling in that plan. This will result in your Disenrollment from MedicareComplete.
- If you want to return to Original Medicare and also want to join a Prescription Drug Plan, simply enroll in a Prescription Drug Plan available in your area. This will automatically Disenroll you from MedicareComplete and return you to Original Medicare.
- If you want to return to Original Medicare and do not want to join a Prescription Drug Plan, simply call Customer Service or Medicare at the phone number above and request to be Disenrolled from MedicareComplete. You will automatically return to Original Medicare.

If you want to Disenroll from a MedicareComplete "medical only" plan without Medicare Part D drug coverage between January 1, 2007 and March 31, 2007:

- You may switch to another Medicare Advantage Plan without Medicare Part D drug coverage by simply enrolling in that plan. This will result in your Disenrollment from MedicareComplete.

If you want to Disenroll from a MedicareComplete plan with Medicare Part D drug coverage between January 1, 2007 and March 31, 2007:

- You may switch to another Medicare Advantage Plan with Medicare Part D drug coverage by simply enrolling in a Medicare Advantage Plan with Medicare Part D drug coverage. This will result in your Disenrollment from MedicareComplete.
- You may enroll in a Prescription Drug Plan and return to Original Medicare by simply enrolling in a Prescription Drug Plan. This will result in your Disenrollment from MedicareComplete and your return to Original Medicare.

We cannot accept Disenrollment requests from Members in a MedicareComplete plan with Medicare Part D drug coverage between January 1, 2007 and March 31, 2007.

The Effective Date of Your Disenrollment

Written Disenrollment requests received by us between **November 15, 2006 and December 31, 2006** will make your MedicareComplete plan Disenrollment effective on January 1, 2007. Until January 1, 2007, you will continue to be a Member of MedicareComplete and must continue to receive all routine Covered Services from Contracting Medical Providers.

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In most cases, a written Disenrollment request from a Member enrolled in a MedicareComplete plan without Medicare Part D drug coverage received by us between **January 1, 2007 and March 31, 2007** will make your Disenrollment effective the first day of the month following the month of your request. For example, if your Disenrollment request is received on January 31, your Disenrollment from MedicareComplete would be processed for an Effective Date of February 1.

Until your membership ends, you will continue to be a Member of MedicareComplete and must continue to receive all routine Covered Services from Contracting Medical Providers until the date your Disenrollment is effective. We will send you a letter that informs you when your Disenrollment is effective. Once your Disenrollment is effective, you may begin using your red, white and blue Medicare card to obtain services under Medicare unless you have joined another Coordinated Care Plan. **Note:** If you need a new Medicare card, call the Social Security Administration Office at 1-800-772-1213 toll-free, (TTY 1-800-325-0778 toll-free). You also may visit the Social Security Web site at *www.ssa.gov.*

Moving or an Extended Absence from the Service Area

If you are permanently moving out of the Service Area or plan an extended absence of more than six (6) months, you must notify us and your Plan Sponsor of the move or extended absence before you leave the Service Area. If you move permanently out of our Service Area, or if you are away from our Service Area for more than six (6) consecutive months, you will need to Disenroll from MedicareComplete.

Failure to notify us of a permanent move or an extended absence may result in your involuntary Disenrollment from MedicareComplete, because we are required to Disenroll you if you have moved out of the Service Area for more than six (6) months. If you remain enrolled after a move or extended absence (and have not been involuntarily Disenrolled as described above), you should be aware that services will not be covered unless they are received from Contracting Medical Providers (except for Emergency Services, Urgently Needed Services and Prior Authorized Referrals).

MedicareComplete Medicare Advantage plans are currently offered in more than 30 states. In addition, other SecureHorizons plans are offered in all 50 states and the District of Columbia. If you are moving outside of your Service Area, you may be eligible to enroll in a MedicareComplete plan in your new location. Please contact your Plan Sponsor to determine the availability of their MedicareComplete Retiree Plan, or other health plan options available to you. Health Plan Premiums if applicable, Copayments, Covered Services and benefit plan types may vary from one area to another. For information and assistance in completing any necessary paperwork, call Customer Service.

For information on other plans available in your area, call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week or visit the CMS Web site at *www.medicare.gov.*

What happens if MedicareComplete leaves the Medicare Program or leaves the Service Area where you live?

If we leave the Medicare program or discontinue MedicareComplete in your Service Area, we will notify you in writing. **If either of these situations occurs, you will be allowed to change the way you receive Medicare coverage.** Your choices will always include Original Medicare, and they may also include joining another Medicare Advantage Plan, if such plans are available in your area and are accepting new Members. However, you should consult with your Plan Sponsor to determine your health care coverage options.

We have a contract with CMS. At the end of each year, the contract is reviewed, and either we or CMS may decide to terminate the contract. It is also possible our contract may terminate at some other time. If the contract is going to terminate, we will generally notify you at least ninety (90) days in advance. Your advance notice may be as little as thirty (30) days, or even fewer days if CMS terminates our contract in the middle of the year.

Until we notify you in writing that you must Disenroll from MedicareComplete and indicate the date when your membership ends, you will continue as a Member of MedicareComplete, and you must continue to receive all Covered Services from Contracting Medical Providers until the

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date your Disenrollment is effective. All Covered Services and rules described in this document will continue until your membership ends.

Once we have notified you in writing we are leaving the Medicare program or the area where you live, you may switch to another way of getting your Medicare benefits at any time. If you decide to switch from MedicareComplete to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called "guaranteed issue rights." You may contact Health Insurance Counseling & Advocacy Program (HICAP), 1300 National Dr., Suite 200, Sacramento, CA 95834, (916) 419-7500, in-state calls only: 1-800-434-0222, TTY 1-800-735-2929, about how and when to buy a Medigap policy if you need one.

Coverage that ends during an inpatient Hospital Stay

If your coverage under MedicareComplete ends while you are an inpatient in a Hospital (or Hospital unit), we may be responsible for the inpatient services until the date of your discharge. Our Customer Service Representatives can advise you if we are responsible for your inpatient services. We are not responsible for services, other than inpatient Hospital services, furnished on or after the Effective Date of your Disenrollment.

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Involuntary Disenrollment

We **must** Disenroll you from the MedicareComplete Retiree Plan under the conditions listed below (you will not be Disenrolled due to your health status):

- If you move out of the Service Area or live outside the Service Area for more than six (6) months at a time and do not voluntarily Disenroll.
- If you do **not** stay continuously enrolled in both Medicare Part A and Medicare Part B.

You **may** be Disenrolled from MedicareComplete under the following conditions:

- If you provide information on your Enrollment Application Form that is false or deliberately misleading and it affects whether or not you may enroll in MedicareComplete.
- If you behave in a way that is unruly, uncooperative, disruptive or abusive, and this behavior seriously affects our ability to arrange Covered Services for you or for others who are Members of MedicareComplete. Before we can Disenroll you for this reason, we **must obtain permission** from the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare.
- If you allow someone else to use your MedicareComplete plan identification card to obtain Covered Services. Before we will Disenroll you for this reason, we must refer your case to the Inspector General, which may result in criminal prosecution.
- If your Plan Sponsor does not pay the Health Plan Premiums on your behalf, you may be disenrolled. See Section 7 "Premiums and Payments" of this Evidence of Coverage and Disclosure Information.

You have the right to file a complaint if we Disenroll you from MedicareComplete

If we Disenroll you from MedicareComplete, we will inform you of the reasons in writing and explain how you may file a Grievance if you so choose.

Until we notify you in writing that you have been Disenrolled, you will continue to be a MedicareComplete plan Member and must continue to obtain routine Covered Services from Contracting Medical Providers. Neither we nor Medicare will pay for services received from Non-Contracting Providers except for Urgently Needed Services, Emergency Services anywhere in the world, out-of-area renal dialysis services and routine travel dialysis.

We cannot Disenroll you due to your health

You may only be Disenrolled from MedicareComplete under certain special conditions that are described above. These conditions do not include Disenrolling you due to your health status. No Member of any Medicare health plan may be Disenrolled from the plan for any health-related reasons.

If you ever feel you are being encouraged or asked to Disenroll from MedicareComplete due to your health status, you should call the national Medicare help line 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), 24 hours a day, 7 days a week.

University of California Rules Related to Fraud

Coverage for a Retiree or covered Dependent may be terminated for fraud or deception in the use of the services of the plan, or for knowingly permitting such fraud or deception by another. Deception includes, but is not limited to, intentionally enrolling an ineligible individual. Such termination shall be effective upon the mailing of written notice by the plan to the Retiree and the University. A Dependent who commits fraud or deception will be permanently de-enrolled while any other Dependent and the Retiree will be de-enrolled for 12 months. If a Retiree commits fraud or deception, the Retiree and any Dependents will be de-enrolled for 12 months.

Review of Termination and Reinstatement

No Member shall be Disenrolled due to the Member's health status or requirements for health care services, other than as stated within this Section. Any Member who believes he/she was Disenrolled by MedicareComplete due to the Member's health status or requirements for health care services, may request a review by the California Director of Managed Health Care, pursuant to California Health and Safety Code, Section 1365, or call the national Medicare help line at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week. In the event the Director determines the Disenrollment was contrary to Section 1365, the Member shall be reinstated retroactively to the date of the Disenrollment.

Section 10

Plan Limitations and Exclusions

All services, procedures, treatments and supplies for medical care, and conditions within each of the following classifications, shall be **limited** under this plan as specifically described below.

1. Out-of-area follow-up care is limited to care which continues to qualify as either emergency or urgently needed care. Routine travel dialysis must be provided at a Medicare-certified facility within the United States.
2. Proton beam therapy for the medically appropriate treatment of prostate cancer is a covered service. Prior authorization must be obtained for all treatment in order for the proton beam therapy to be considered a covered service. Coverage for proton beam therapy for the treatment of prostate cancer is limited to a maximum of the Original Medicare allowable amount for conformal 3D photon beam therapy treatments for prostate cancer. Coverage is subject to coinsurance, including, but not limited to, coinsurance for radiation therapy. Members are responsible for any amounts in excess of Original Medicare allowable amounts, and for any travel or other costs associated with obtaining proton beam therapy treatment of prostate cancer.
3. The MedicareComplete Plan covers outpatient injectables on the MedicareComplete Plan list of outpatient injectables in accordance with Medicare guidelines. Prior authorization is required, and applicable coinsurance is required for a 30-day supply, course of therapy or treatment of an acute episode, whichever is shorter. No more than a 30-day supply will be dispensed at one time and must be obtained through a contracting provider. **Note:** The outpatient injectable copayment applies regardless of where the outpatient injection is administered, including, but not limited to, physician's office and/or outpatient clinic.
4. Bariatric surgical procedures are not covered for the sole purpose of weight loss and/or weight management. Bariatric surgery will only be covered when medically necessary for the treatment of morbid obesity, in accordance with CMS National Coverage Determination. This program includes, but is not limited to, a multidisciplinary nonsurgical approach of supervised diet, exercise and behavioral modification. We reserve the right to designate the providers and facilities within the Member's Contracting Medical Group/IPA or Network based on a number of factors, including training and experience, cost and surgical results. Surgical treatment for morbid obesity and services related to Bariatric surgery are subject to prior approval by the Member's Contracting Medical Group/IPA or one of our Medical Directors.

The following services, procedures, treatments and supplies are **excluded** from coverage:

1. Any service, procedure, treatment, supply or medication not specifically included in the Retiree Benefits Summary; any service,

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procedure, treatment, supply or medication not provided, arranged or authorized by a Contracting Medical Provider or us (except for Emergency or Urgently Needed Services) or services, procedures, treatments and supplies obtained prior to a Member's start date of coverage or after termination of coverage.

2. All items and services, procedures, treatments and supplies which are not Medically Necessary to treat an illness or injury, and which do not meet Medicare program standards.
3. Procedures, services, treatments, supplies and medications, until they are reviewed for safety, efficacy and cost-effectiveness and approved by us.
4. Non-authorized emergency facility services for routine conditions.
5. Items and services determined by us or Medicare to be experimental or investigational, and that do not qualify for Medicare coverage, unless for certain services covered under an approved Medicare clinical trial. (See Section 5 for more information about Medicare clinical trials.)
6. A private room in a Hospital or a Skilled Nursing Facility, except when medically necessary.
7. Private duty nursing care.
8. Nursing care on a full-time basis in your home.
9. Personal convenience items, such as a telephone or television in a Member's room at a Hospital or Skilled Nursing Facility, and items for the home, such as air conditioners, air purifiers, or other environmental equipment.
10. Optional additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the Member, or for ambulation primarily in the community, including home and car remodeling or modification.
11. Custodial care, which includes, but is not limited to, care that assists Members in the activities of daily living, such as walking, getting in and out of bed, feeding, bathing, dressing, and using the toilet; preparation of special diets; supervision of the administration of medication that is usually self-administered; and meals delivered to the Member's home, regardless of the setting, which includes, but is not limited to, rest homes, a home for the aged, personal residences, assisted living facilities, residential living or similar facilities.
12. Homemaker or Home Health Aide services, except those covered in accordance with Medicare guidelines.
13. Services performed by immediate relatives or members of your household.
14. Unless medically necessary to treat a medical illness or injury, elective or voluntary enhancement services, procedures, treatments, supplies and medications, including but not limited to, services related to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
15. Cosmetic surgery, except for such plastic and reconstructive surgery as may be necessary due to accidental injury or to improve the function of a malformed body part. Breast reconstruction is covered only following a mastectomy, in accordance with Medicare guidelines.
16. Dental services, except those dental services covered under the MedicareComplete medical benefit or as described in the Retiree Benefits Summary.
17. Dental splints, dental prosthesis or any dental treatment for the teeth, gums or jaw or dental treatment related to temporomandibular joint syndrome (TMJ), except when Medicare criteria are met.
18. Drugs prescribed by a dentist or drugs used for dental treatment.
19. Chiropractic services, except in accordance with Medicare guidelines for the treatment of subluxation of the spine upon referral from the Member's contracting primary care physician, or as described in the Retiree Benefits Summary.
20. Routine foot care, except in accordance with Medicare guidelines, or as described in the Retiree Benefits Summary.
21. Orthopedic shoes, except when they are part of a leg brace and are included in the orthopedist's charge for the brace. Therapeutic shoes and supportive devices for

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the feet are covered for Members suffering from diabetic foot disease, in accordance with Medicare guidelines.

22. Reversal of sterilization procedures; sex change operations; conception by artificial means, which includes, but is not limited to, insemination procedures, in-vitro fertilization, zygote intrafallopian transfers and gamete intrafallopian transfers; and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Complementary alternative medicine, tradition-based medicine and/or non-conventional medicine, except as covered by Medicare criteria for the treatment of an illness or disease. Examples include, but are not limited to, naturopathy, yoga, polarity, massage therapy, healing touch therapies, bioelectromagnetics and biofeedback.
25. Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
26. All services, procedures, treatments, medications and supplies related to Workers' Compensation claims.
27. Physical examinations or immunizations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.
28. Aqua therapy, except as part of a multi-modality authorized treatment plan with a licensed therapist in attendance.
29. Substance abuse detoxification and rehabilitation, except as covered in accordance with Medicare guidelines.
30. Abortion, except for cases resulting in pregnancies from rape or incest or that endanger the life of the mother.
31. Smoking cessation products and treatments, except as covered in accordance with Medicare guidelines.
32. Non-emergency transportation, except as described in the Retiree Benefits Summary.
33. Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), except when Medicare criteria are met.
34. Long-term services beyond that which Medicare would cover, except as determined by us to be less costly alternatives to the basic minimum benefit.
35. Prenatal, maternity or post-partum care for a non-Plan Member acting as a surrogate.
36. LASIK, surgeries or other laser procedures for refractive error.
37. Routine vision services, including
    - Routine vision services, not described in the Retiree Benefits Summary. Orthoptics or vision training and any associated supplemental testing.
    - Medical or surgical treatment of the eyes for refractive errors or cosmetic purposes.
    - Plano lenses (non-prescription).
    - Two pair of glasses in lieu of bifocals.
    - Subnormal (low) vision aids.
    - Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
    - Any eye examination or corrective eyewear, required by an employer as a condition of employment.
    - Conditions covered by Workers' Compensation.
    - Any service or material provided by another vision or medical plan or non-contracting provider.
    - Cosmetic services and/or materials, including but not limited to, blended (no-line) bifocal or trifocal lenses, oversize lenses (62 mm or greater), photochromic lenses, tinted lenses except Pink or Rose #1 or #2, progressive or multifocal lenses, the coating or laminating of the lens or lenses, UV (ultraviolet) lenses, polycarbonate/high index lenses, anti-reflective coating, scratch resistant coating, edge polish, cosmetic lenses and other cosmetic processes.

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- Eyeglasses when the change in prescription is less than .50 Diopter.
- Charges in excess of the reasonable and customary charges.
- Charges incurred after the Vision Plan terminates or coverage is ended.
- Experimental or non-conventional treatment or devices.

Section 11

Coordinating Other Benefits You May Have

If you have other health insurance coverage, in addition to MedicareComplete, it is important to use this other coverage **in combination with** your MedicareComplete plan coverage to help pay for the cost of the Covered Services you receive. The use of other health insurance available to you with your MedicareComplete plan coverage is called "coordination of benefits" because it involves coordinating all of your health care coverage.

Please keep us up to date on any other health insurance coverage you have, such as the following:

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- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse
- Coverage that you have under Workers' Compensation because of a job-related illness or injury or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage through the "TriCare for Life" program (veterans' benefits)
- Coverage you have for dental insurance or prescription drugs
- "Continuation coverage" that you have through the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Who Pays First?

As a Member, you are always entitled to receive Covered Services through the MedicareComplete plan. Medicare law, however, gives us or our designee the right to recover payments from certain "third party" insurance companies or from you, if you were paid by a "third party." Because of this, we may ask you for information about other insurance you may have. If you have other insurance, you can help us obtain payment from the other insurer by promptly providing the requested information.

If any no-fault or any liability insurance is available to you, benefits under that plan must be applied to the costs of health care covered by that plan. Where we have provided benefits, and a judgment or settlement is made with a no-fault or liability insurer, you must reimburse us or our designee (entity or person selected for this purpose) to the extent of your medical expenses. However, our reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' Compensation from treatment of a work-related illness or injury should also be applied to covered health care costs.

If you do not have end-stage renal disease (ESRD), and have coverage under an employer group plan of an employer of twenty (20) or more employees, either through your own current employment or the employment of a spouse, you must use the benefits under that plan prior to using your MedicareComplete plan benefits. Similarly, if you do not have end-stage renal disease (ESRD), but have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) through a spouse's employer group coverage, you must use the benefits under that plan prior to using your MedicareComplete plan benefits. In such cases, you will only receive benefits not covered by your employer group plan through our contract with Medicare (and we will only be paid an amount by Medicare to cover such "wrap-around" benefits). A special rule applies if you have or develop ESRD.

If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. However, if your employer group plan coverage was secondary to Medicare when you developed ESRD, because it was not based on current employment as described above, Medicare continues to be the primary payer.

Section 12

Advance Directives: Making Your Health Care Wishes Known

We are required by law to inform you of your right to make health care decisions and to execute an Advance Directive. An Advance Directive is a formal document, written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, Contracting Medical Providers will honor your wishes. If you become so sick that you cannot speak for yourself, this directive will guide your health care Providers in treating you, and will save your family, friends and physicians from having to guess what you would have wanted.

There may be several types of Advance Directives you may choose from, depending on State law. Most States recognize:

1. DPAHC (Durable Power of Attorney for Health Care)/Medical Durable Power of Attorney
2. Health Care Directive
3. Living Wills
4. Natural Death Act Declarations
5. Cardiopulmonary Resuscitation (CPR) Directive
6. Do Not Resuscitate (DNR) Orders

You are not required to initiate an Advance Directive, and you will not be denied care if you do not have an Advance Directive.

If you choose to have an Advance Directive, you must provide copies of your completed directive to the following:

1. Your Primary Care Physician/Contracting Medical Provider
2. Your agent or representative (if you have one)
3. Your family

If you decide that you want to have an Advance Directive, there are several ways to get this type of legal form. You may get a form from your lawyer, from a social worker, the Internet and from some office supply stores.

Take a copy of your Advance Directive to the Hospital when you are hospitalized. If you have questions regarding the creation of an Advance Directive or end of life treatment decisions, or if you want file a complaint because believe your rights related to the creation and use of an Advance Directive have not been respected, please contact Health Insurance Counseling & Advocacy Program (HICAP), 1300 National Dr., Suite 200, Sacramento, CA 95834, (916) 419-7500, in-state calls only: 1-800-434-0222, TTY 1-800-735-2929 for assistance.

Section 13

General Provisions

Governing Law

This Evidence of Coverage and Disclosure Information is subject to the laws of Title XVIII of the Social Security Act and regulations promulgated thereunder by CMS. In addition, other federal laws may apply and, under certain circumstances, the state laws may apply. Any provisions required to be in this Evidence of Coverage and Disclosure Information by any of the above acts and regulations shall bind UnitedHealthcare and you, whether or not expressly provided in this document.

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Your Financial Liability as a MedicareComplete Retiree Plan Member

As a Member of the MedicareComplete Retiree Plan, you have the following financial obligations:

All Copayments and Coinsurance specified in the Retiree Benefits Summary must be paid to the Contracting Medical Provider at the time of service.

Health Plan Premium

Rate changes for MedicareComplete Retiree Plan Members are subject to contractual arrangements between UnitedHealthcare and the University of California (Plan Sponsor). Your Plan Sponsor is responsible for notifying you of any MedicareComplete Retiree Plan health plan premium changes, contribution changes or employer sponsored benefit changes thirty (30) days before they become effective.)

Member Liability

In the event we fail to reimburse Contracting Medical Providers' charges for Covered Services, or in the event that we fail to pay a Non-Contracting Medical Provider for Prior Authorized services occurring when you were actively enrolled in MedicareComplete, you will not be liable for any sums owed by us.

However, you will be liable if you receive services from Non-Contracting Medical Providers without Prior Authorization. Neither UnitedHealthcare nor Medicare will pay for those services except for:

- **Emergency Services**
- **Urgently Needed Services**
- **Out-of-area and routine travel renal dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)**
- **Post-stabilization services**

In addition, if you enter into a private contract with a Non-Contracting Medical Provider, neither UnitedHealthcare nor Medicare will pay for those services.

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Third Party Liability

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, we shall furnish all Covered Services. However, you agree to fully reimburse us or our designee for the cost of all such services and benefits provided, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of UnitedHealthcare or its designee under this provision. You shall not settle any claim, or release any person from liability, without the written consent of UnitedHealthcare, wherein such release or settlement will extinguish or act as a bar to our right of reimbursement.

Reimbursement of third party medical expenses

If you receive medical services under your MedicareComplete plan coverage after being injured through the actions of another person (a third party) for which you receive a monetary recovery, you will be required to reimburse us, or our designee, to the extent permitted under State and federal law, for the cost of such medical services and benefits provided and the reasonable costs actually paid to perfect any lien.

You must obtain the written consent of UnitedHealthcare or its nominee (entity or person authorized to give consent) prior to settling any claim, or releasing any third party from liability, if such settlement or release would limit the reimbursement rights of UnitedHealthcare or its nominee.

You are required to cooperate in protecting the interests of UnitedHealthcare or its nominee by providing all liens, assignments or other documents necessary to secure reimbursement to us or our nominee. Failure to cooperate with us or our nominee in this regard could result in termination of your MedicareComplete plan Membership.

Should you settle your claim against a third party and compromise the reimbursement rights of UnitedHealthcare or its nominee without our written consent, or otherwise fail to cooperate in protecting the reimbursement rights of UnitedHealthcare or its nominee, we may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

Non-duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care Provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your MedicareComplete plan Membership.**

Acts Beyond Our Control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, Contracting Medical Providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for Covered Services insofar as practical and according to our best judgment. Neither we nor any Contracting Medical Provider shall have any liability or obligation for delay or failure to provide or arrange for Covered Services if such delay is the result of any of the circumstances described above.

Contracting Medical Providers and Network Hospitals Are Independent Contractors

The relationships between us and our Contracting Medical Providers and Network Hospitals are independent contractor relationships. None of the Contracting Medical Providers or Network Hospitals or their physicians or employees are employees or agents of UnitedHealthcare. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare is an employee or agent of the Contracting Medical Providers or Network Hospitals.

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Our Contracting Arrangements

In order to obtain quality service in an efficient manner, we pay its Providers using various payment methods, including capitation, per diem, incentive and discounted Fee-for-Service arrangements. Capitation means paying an agreed-upon dollar amount per month for each Member assigned to the Provider. Per diem means paying a fixed dollar amount per day for all services rendered, such as Inpatient Hospital and Skilled Nursing Facility stays. Incentive means a payment that is based on appropriate medical management by the Provider. Discounted Fee-for-Service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the Contracting Medical Providers that may affect the use of Referrals and other services that you might need. To obtain this information, call Customer Service and request information about the Contracting Medical Provider's payment arrangements.

How Our Contracting Providers Are Compensated

The following is a brief description of how we pay our Contracting Medical Providers:

We typically contract with individual physicians and medical groups/IPAs to provide medical services and with Hospitals to provide Hospital services to Members. The Contracting Medical Groups/IPAs in turn, employ or contract with individual physicians.

Most of the individual physicians are paid on a Fee-for-Service arrangement. In addition, some physicians receive an agreed-upon monthly payment from us to provide services to Members. The monthly payment may be either a fixed dollar amount for each Member, or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by individual physicians and may also cover certain Referral services.

Most of the Contracting Medical Groups/IPAs receive an agreed upon monthly payment from us to provide services to Members. The monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by the Contracting Medical Group/IPA, and may also cover certain Referral services. Some of our Network Hospitals receive similar monthly payments in return for arranging Hospital services for Members. Other Hospitals are paid on a discounted Fee-for-Service or fixed charge per day of hospitalization.

Each year, we and the Contracting Medical Group/IPA agree on a budget for the cost of services covered under the program for all MedicareComplete plan Members treated by the Contracting Medical Group/IPA. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Contracting Medical Group/IPA shares in the savings. The Network Hospital and the Contracting Medical Group/IPA typically participate in programs for Hospital services similar to that described above.

Stop-loss insurance protects the Contracting Medical Groups/IPAs and Network Hospitals from large financial losses and helps the Providers with resources to cover necessary treatment. We provide stop-loss protection to the Contracting Medical Groups/IPAs and Network Hospitals that receive capitation payments. If any capitated Providers do not obtain stop-loss protection from us, they must obtain stop-loss insurance from an insurance carrier acceptable to us. You may obtain additional information on compensation arrangements by contacting Customer Service or your Contracting Medical Group/IPA.

Technology Assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Copayments, Coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, one of our Medical Directors makes a medical necessity determination based on individual Member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

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Information upon request

As a MedicareComplete plan Member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality Improvement Programs
- Statistical data on Grievances and Appeals
- The financial condition of UnitedHealthcare

Section 14

MedicareComplete Service Area

This is the statewide Service Area listing for MedicareComplete. Benefit plans are specific to the Service Area.

You are eligible for enrollment and continued coverage as long as you reside in one of the counties listed below:

Alameda, Contra Costa, Fresno, Kern, Los Angeles,* Orange, Sacramento, Santa Clara, Santa Cruz, San Francisco, San Joaquin, Stanislaus

*Excluding Zip Code 90704

You are also eligible for enrollment and continued coverage as long as you reside in one of the following Zip Codes in the counties listed below:

Madera County
93601, 93604, 93614, 93643, 93644, 93645, 93669

Nevada County
95712, 95924, 95945, 95946, 95949, 95959, 95960, 95975, 95977

Placer County
95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95717, 95722, 95736, 95746, 95747, 95765

Riverside County
91752, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92230, 92234, 92235, 92236, 92239, 92240, 92241, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92292, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92515, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883

San Bernardino County

91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91761, 91762, 91763, 91764, 91766, 91784, 91785, 91786, 91798, 92252, 92256, 92284, 92285, 92286, 92301, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92316, 92318, 92323, 92324, 92327, 92329, 92334, 92335, 92336, 92337, 92338, 92339, 92340, 92342, 92344, 92345, 92346, 92347, 92350, 92354, 92356, 92357, 92358, 92364, 92365, 92366, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92382, 92392, 92393, 92394, 92395, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92412, 92413, 92415, 92418, 92423, 92424, 92427

San Diego County

91901, 91902, 91903, 91905, 91906, 91908, 91909, 91910, 91911, 91912, 91913, 91914, 91915, 91916, 91917, 91921, 91931, 91932, 91933, 91934, 91935, 91941, 91942, 91943, 91944, 91945, 91946, 91947, 91948, 91950, 91951, 91962, 91963, 91976, 91977, 91978, 91979, 91980, 91987, 91990, 92003, 92007, 92008, 92009, 92010, 92011, 92013, 92014, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92033, 92037, 92038, 92039, 92040, 92046, 92049, 92051, 92052, 92054, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92064, 92065, 92066, 92067, 92068, 92069, 92070, 92071, 92072, 92074, 92075, 92078, 92079, 92081, 92082, 92083, 92084, 92085, 92086, 92088, 92090, 92091, 92092, 92093, 92096, 92101, 92102, 92103, 92104, 92105, 92106, 92107, 92108, 92109, 92110, 92111, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92127, 92128, 92129, 92130, 92131, 92132, 92133, 92134, 92135, 92136, 92137, 92138, 92139, 92140, 92142, 92143, 92145, 92147, 92149, 92150, 92152, 92153, 92154, 92155, 92159, 92160, 92161, 92162, 92163, 92164, 92165, 92166, 92167, 92168, 92169, 92170, 92171, 92172, 92173, 92174, 92175, 92176, 92177, 92178, 92179, 92182, 92184, 92186, 92187, 92190, 92191, 92192, 92193, 92194, 92195, 92196, 92197, 92198, 92199

San Luis Obispo County

93401, 93402, 93403, 93405, 93406, 93407, 93408, 93409, 93410, 93412, 93420, 93421, 93424, 93428, 93430, 93433, 93435, 93442, 93443, 93444, 93445, 93448, 93449, 93452, 93453, 93454, 93483

San Mateo County

94002, 94010, 94011, 94019, 94027, 94030, 94061, 94062, 94063, 94065, 94066, 94070, 94080, 94083, 94096, 94098, 94099, 94128, 94303, 94401, 94402, 94403, 94404, 94497

Santa Barbara County

93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199, 93254, 93427, 93434, 93440, 93441, 93454, 93455, 93456, 93457, 93458, 93460, 93463, 93464

Sonoma County

94922, 94923, 94926, 94927, 94928, 94931, 94951, 94952, 94953, 94954, 94955, 94972, 94975, 94999, 95401, 95402, 95403, 95404, 95405, 95406, 95407, 95408, 95409, 95416, 95419, 95421, 95425, 95430, 95431, 95433, 95436, 95439, 95441, 95442, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471, 95472, 95473, 95476, 95486, 95487, 95492

Ventura County

90265, 91302, 91307, 91361, 93001, 93002, 93003, 93004, 93005, 93006, 93007, 93009, 93010, 93011, 93012, 93013, 93015, 93016, 93022, 93023, 93024, 93030, 93031, 93032, 93033, 93034, 93035, 93036, 93040, 93041, 93042, 93043, 93044, 93060, 93061, 93064, 93066, 93099

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P.O. Box 29800
Hot Springs, AR 71903-9800

Customer Service
1-866-622-8055
TTY 1-888-685-8480
8 a.m. to 8 p.m.
Sunday through Saturday

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Visit our Web site at
www.securehorizons.com

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