Summary Plan Description

UnitedHealthcare Consumer Directed Health Plan

Effective January 1, 2011
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| Information about the UnitedHealthcare CDH Plan | 1-800-842-9722 | myuhc.com |
| Information about prescription drugs Medco Health Solutions | 1-800-311-0835 | medco.com myuhc.com |
| Information about mental health and substance abuse UnitedHealthcare/United Behavioral Health | 1-800-842-9722 | liveandworkwell.com (access code: wells Fargo) myuhc.com |
| | Employee Assistance Consulting (EAC) 1-888-327-0027 | For TDD access for persons with hearing impairments, please call 1-877-411-0826 eac.portal.wellsfargo.com |
| Information about premiums for the UnitedHealthcare CDH Plan | Check your enrollment materials, or go to Teamworks. |
| Information about providers in your area Teamworks |
| Provider Directory Service geoaccess.com/directoriesonline/wf/ |
| Wells Fargo Medical Plan Comparison Tool wf.choser.pbgh.org |
| Information about enrollment Teamworks |
| HR Service Center 1-877-HRWELLS (1-877-479-3557) For TDD access for persons with hearing impairments, please call 1-800-988-0161 hrsc@wellsfargo.com |
Chapter 1
Administrative information

The basics
This Summary Plan Description (SPD) covers the provisions of the UnitedHealthcare Consumer Directed Health Plan (the Plan).

While reading this material, be aware that:

• The Plan is a welfare benefits plan provided as a benefit to eligible team members and their eligible dependents. Participation in this Plan does not constitute a guarantee or contract of employment with Wells Fargo & Company or its subsidiaries. Plan benefits depend on continued eligibility.

• The name “Wells Fargo,” as used throughout this document, refers to Wells Fargo & Company.

In case of any conflict between the SPD, any other information provided, and the official Plan document, the Plan document governs plan administration and benefits decisions. You may request a copy of the official Plan document by submitting a written request to the address below, or you may view the document on-site during regular business hours by prior arrangement:

Compensation and Benefits Department
Wells Fargo
MAC N9311-170
625 Marquette Avenue
Minneapolis, MN 55479

Wells Fargo contracts with third-party administrators to provide claims administrative services. These third-party administrators are referred to as claims administrators.

While the Plan’s provisions determine what services and supplies are eligible for benefits, you and your health care provider have ultimate responsibility for determining appropriate treatment and care.

Responsibilities of covered persons
Each covered team member and covered dependent is responsible for reading this SPD and related materials completely and complying with all rules and Plan provisions.

Definition of a Summary Plan Description (SPD)
An SPD explains your benefits and rights under the Plan. The SPD includes this booklet and the first chapter and the appendixes of your Benefits Book. The Benefits Book and SPDs are available on Teamworks at work and at home. Every attempt has been made to make the Benefits Book and SPDs easy to understand, informative, and as accurate as possible. However, an SPD cannot replace or change any provision of the actual Plan documents.

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For a list of specific rights, review the section “Your rights under ERISA” in “Appendix B: Legal notifications” of your Benefits Book.

Who’s eligible
Each team member who satisfies the Plan’s eligibility requirements may enroll. Your employment classification determines eligibility to participate in this Plan. For more information regarding employment classification and eligibility, refer to the first chapter of your Benefits Book.

Plan information

Claims administrator
UnitedHealthcare (UHC) is the organization designated by the plan administrator to receive, process, and administer claims for benefits described in Chapter 2 of this SPD and make claim payments for such benefits on behalf of the Plan. UHC is the claims fiduciary for claims for benefits described in Chapter 2 of this SPD.

Medco Health Solutions, Inc. (Medco) is the organization designated by the plan administrator to receive, process, and administer claims for prescription drug benefits described in Chapter 3 of this SPD and make claim payments for such benefits on behalf of the Plan. Medco is the claims fiduciary for claims for prescription drug benefits described in Chapter 3 of this SPD.

United Behavioral Health (UBH) is the organization designated by the plan administrator to receive, process, and administer claims for mental health and substance abuse benefits described in Chapter 4 of this SPD and make claim payments for such benefits on behalf of the Plan. UBH is the claims fiduciary for claims for mental health and substance abuse benefits described in Chapter 4 of this SPD.

UnitedHealthcare Consumer Directed Health Plan

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UHC, Medco, and UBH are not the administrators for appeals related to rescission of coverage. Wells Fargo Corporate Benefits has the discretionary authority to determine whether medical coverage will be rescinded (retroactively canceled). Please see “Appendix A: Claims and appeals” of the Benefits Book for more details.

Contact information for each of the claims administrators is provided below:

- UnitedHealthcare
  PO Box 30884
  Salt Lake City, UT 84130
  1-800-842-9722

Note: UnitedHealthcare contact information also applies for UBH.

- Medco Health Solutions
  PO Box 14711
  Lexington, KY 40512
  1-800-311-0835
How the Plan works

The UnitedHealthcare Consumer Directed Health Gold and Silver Plans and the Indemnity Plan (hereinafter referred to as the “UnitedHealthcare CDH Plan”) is offered nationwide. To receive the highest level of benefits, you must use UnitedHealthcare’s network of providers. If you do not use UnitedHealthcare’s network of providers, services defined as covered health services under the UnitedHealthcare CDH Plan are covered, but you will pay a greater share of the cost. The UnitedHealthcare CDH Plan is self-insured by Wells Fargo. UnitedHealthcare is the claims administrator.

A self-insured plan means benefits are paid from company and team member contributions. Wells Fargo contracts with UnitedHealthcare (the claims administrator) to perform administrative services and process claims, and the claims administrator, in turn, contracts with hospitals and doctors to create the UnitedHealthcare network. UnitedHealthcare does not guarantee any benefits. Wells Fargo is solely responsible for paying benefits described in this SPD. Additionally, Medco Health Solutions is the claims administrator for prescription drugs and United Behavioral Health is the claims administrator for mental health and substance abuse benefits.

For more information on benefits, visit Teamworks, sign on to myuhc.com, or call the number on the back of your ID card.

If you enroll in the UnitedHealthcare CDH Plan, you may access mental health and substance abuse benefits administered by United Behavioral Health. Benefits through United Behavioral Health are covered by the Health Reimbursement Account (HRA) and are combined with the deductible and maximums under the UnitedHealthcare CDH Plan.

When you enroll in the UnitedHealthcare CDH Plan, you agree to give your health care providers permission to provide the claims administrator, UnitedHealthcare, access to required information about the care provided to you. UnitedHealthcare keeps all such information strictly confidential. The claims administrator may require this information to process claims and conduct utilization review for quality improvement activities and for other health plan activities, as permitted by law.

The claims administrator may release the information, if you authorize them to do so or if state or federal law permits or allows release without your authorization. If a provider requires a special authorization for release of records, you agree to provide the authorization. Your failure to provide authorization or requested information may result in denial of your claim.

As always, it is between you and your provider to determine the treatments and procedures that best meet your needs. The terms of the UnitedHealthcare CDH Plan control what, if any, benefits are available for the services you receive. The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is a covered health service as defined by the UnitedHealthcare CDH Plan. The definition of a covered health service (see the “Covered health services” section on page 13) relates only to what is covered by the UnitedHealthcare CDH Plan and may differ from what your physician deems to be a covered health service.

If you live within the network area, you may choose to use any network or out-of-network provider.
UnitedHealthcare CDH Plan: Your benefits and costs at a glance

These benefits and cost-sharing amounts apply to individuals enrolled in the Plan and are subject to the procedures, exclusions, and limitations in this SPD.

<table>
<thead>
<tr>
<th>Coverage category</th>
<th>Annual allocation of HRA benefit dollars (includes medical, pharmacy, and mental health and substance abuse)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gold</td>
</tr>
<tr>
<td>Team member</td>
<td>$1,000</td>
</tr>
<tr>
<td>Team member + spouse* or child(ren)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your deductible responsibility</th>
<th>Annual deductible (includes medical, pharmacy, and mental health and substance abuse)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gold</td>
</tr>
<tr>
<td>Team member</td>
<td>$1,500</td>
</tr>
<tr>
<td>Team member + spouse* or child(ren)</td>
<td>$2,250</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual coinsurance maximum</th>
<th>Network and out-of-network (combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Gold</td>
</tr>
<tr>
<td>Team member</td>
<td>$2,000</td>
</tr>
<tr>
<td>Team member + spouse* or child(ren)</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

* For the purposes of this document, “spouse” includes your domestic partner or same-sex spouse, unless otherwise noted.
For all benefits listed below, the HRA pays first — 100% of the covered health service. After the HRA is depleted and your deductible responsibility is satisfied, the UnitedHealthcare CDH Plan will pay as shown below unless otherwise noted in this SPD.

<table>
<thead>
<tr>
<th>Network</th>
<th>Out of network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care physician (PCP) requirements</strong></td>
<td>No PCP requirement. See any provider, including specialists, without referral; a network provider will provide services at a discounted rate, which maximizes your HRA and coinsurance.</td>
</tr>
<tr>
<td><strong>Doctor’s office visits</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible. No PCP requirement. See any provider, including specialists, without referral.</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>The Plan pays 100% for eligible preventive care services based on annual exam schedule (expenses are not deducted from HRA with no deductible to satisfy). HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible (no deductible to satisfy), based on annual exam schedule.</td>
</tr>
<tr>
<td><strong>Urgent care clinic visits</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible. HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Emergency room</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible. HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>HRA pays 100%, then you pay 10% of eligible covered expenses after the deductible. HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Hospital care</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible. HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Outpatient surgery and diagnostic and therapeutic services</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible. HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>(including labs and x-rays)</strong></td>
<td>May be performed in a hospital, an outpatient facility, or a doctor’s office.</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td>HRA pays 100%, then you pay 20% after deductible (up to 30-day supply). HRA pays 100%, then you pay 20% after deductible. HRA pays 100%, then you pay 20% after deductible.*</td>
</tr>
<tr>
<td><strong>Retail: generic, brand, nonformulary</strong></td>
<td>HRA pays 100%, then you pay 10% after deductible (up to 90-day supply). Not covered.</td>
</tr>
<tr>
<td><strong>Mail order: generic, brand, nonformulary</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
For all benefits listed below, the HRA pays first — 100% of the covered health service. After the HRA is depleted and your deductible responsibility is satisfied, the UnitedHealthcare CDH Plan will pay as shown below unless otherwise noted in this SPD.

<table>
<thead>
<tr>
<th>Vision and hearing</th>
<th>Network</th>
<th>Out of network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing screenings</td>
<td>Only covered as part of eligible preventive well-child care.</td>
<td>Only covered as part of eligible preventive well-child care.</td>
</tr>
<tr>
<td>Hearing aids (for children up through the calendar year the dependent child turns age 18; limited to one hearing aid or one set of hearing aids every three calendar years, network and out of network combined)</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Eyewear</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family planning</th>
<th>Network</th>
<th>Out of network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits, including infertility studies, vasectomies, tubal ligations, and artificial insemination</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Infertility treatment for diagnosis and treatment for correction of underlying conditions, including artificial insemination for diagnosed infertility, is limited to the lifetime maximum benefit noted above (network and out of network combined)</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>In vitro fertilization, infertility drugs</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapy and chiropractic visits</th>
<th>Network</th>
<th>Out of network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, speech, or occupational therapy: 90 visits per calendar year combined, network and out of network combined</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Chiropractic: 26 visits per calendar year, network and out of network combined</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acupuncture</th>
<th>Network</th>
<th>Out of network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to 26 visits per calendar year, network and out of network combined</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable medical equipment, prosthetics, and supplies</th>
<th>Network</th>
<th>Out of network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
<td></td>
</tr>
</tbody>
</table>

* Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
For all benefits listed below, the HRA pays first — 100% of the covered health service. After the HRA is depleted and your deductible responsibility is satisfied, the UnitedHealthcare CDH Plan will pay as shown below unless otherwise noted in this SPD.

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home health care</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Limited to 100 visits per calendar year, network and out of network combined (home health care and extended skilled nursing combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Homeopathic</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Limited to 20 visits per calendar year, network and out of network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient rehabilitation</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Massage therapy</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
<td>HRA pays 100%, then you pay 40% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Limited to 20 visits per calendar year, network and out of network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental health and substance abuse</strong></td>
<td>Covered under the UnitedHealthcare CDH Plan. Benefits are administered by United Behavioral Health (UBH). (See “Chapter 4: Mental health and substance abuse benefits” starting on page 49 for more information.)</td>
<td></td>
</tr>
<tr>
<td><strong>Disease management</strong></td>
<td>Asthma, chronic obstructive pulmonary diseases, coronary artery disease, heart failure, diabetes.</td>
<td></td>
</tr>
<tr>
<td><strong>Member Services and website</strong></td>
<td>Member Services number on the back of your ID card or myuhc.com.</td>
<td></td>
</tr>
<tr>
<td><strong>Health coaches for members</strong></td>
<td>Health coach number on the back of your ID card or myuhc.com.</td>
<td></td>
</tr>
<tr>
<td><strong>Highlights</strong></td>
<td>Remaining HRA benefit dollars roll over annually for you to use for future covered health services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flexible: No copays; no PCP required, no referrals required to see specialist; 450,000 providers nationwide.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Receive a credit to your HRA if you have diabetes, asthma, coronary artery disease, or hypertension and elect to participate in and complete the Rewards for Action program on myuhc.com. See the “Rewards for Action™ program” section on page 18 for more information.</td>
<td></td>
</tr>
</tbody>
</table>

* Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
UnitedHealthcare CDH Plan, Indemnity Option: Your benefits and costs at a glance

These benefits and cost-sharing amounts apply to individuals who do not reside in the network area and are subject to the exclusions and limitations noted in this SPD.

### The UnitedHealthcare CDH Indemnity Plan

#### Schedule of benefits

<table>
<thead>
<tr>
<th></th>
<th>Annual allocation of HRA benefit dollars (includes medical, pharmacy, and mental health and substance abuse)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gold</td>
</tr>
<tr>
<td>Team member</td>
<td>$1,000</td>
</tr>
<tr>
<td>Team member + spouse* or child(ren)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

#### Your deductible responsibility

Your total annual deductible is a combination of the HRA plus what you pay out of pocket.

<table>
<thead>
<tr>
<th></th>
<th>Annual deductible (includes medical, pharmacy, and mental health and substance abuse)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gold</td>
</tr>
<tr>
<td>Team member</td>
<td>$1,500</td>
</tr>
<tr>
<td>Team member + spouse* or child(ren)</td>
<td>$2,250</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

#### Annual coinsurance maximum

Includes medical, pharmacy, and mental health and substance abuse (excludes deductible).

|                           | Gold | Silver |
| Team member               | $2,000 | $2,000 |
| Team member + spouse* or child(ren) | $3,000 | $3,000 |
| Family                    | $4,000 | $4,000 |

#### Lifetime maximum benefit

Unlimited for most benefits categories; however, some benefits categories have a separate lifetime maximum benefit that is enforced.

* For the purposes of this document, “spouse” includes your domestic partner or same-sex spouse, unless otherwise noted.
For all benefits listed below, the HRA pays first — 100% of the covered health service. After the HRA is depleted and your deductible responsibility is satisfied, the UnitedHealthcare CDH Plan will pay as shown below unless otherwise noted in this SPD.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care physician (PCP) requirements</td>
<td>No PCP requirement. See any provider, including specialists without referral.</td>
</tr>
<tr>
<td>Doctor’s office visits</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Preventive care</td>
<td>The Plan pays 100% for eligible preventive care services based on annual exam schedule (expenses are not deducted from HRA).</td>
</tr>
<tr>
<td>Preventive care</td>
<td></td>
</tr>
<tr>
<td>Preventive care</td>
<td>Annual physicals, well-baby visits, immunizations</td>
</tr>
<tr>
<td>Preventive care</td>
<td></td>
</tr>
<tr>
<td>Urgent care clinic visits</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Emergency room (as defined under Emergency care)</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Maternity</td>
<td>HRA pays 100%, then you pay 10% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Hospital care</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Hospital care</td>
<td>Hospital inpatient charges</td>
</tr>
<tr>
<td>Hospital care</td>
<td>Physician charges</td>
</tr>
<tr>
<td>Hospital care</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery and diagnostic and therapeutic services</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Outpatient surgery and diagnostic and therapeutic services</td>
<td>(including lab and x-rays)</td>
</tr>
<tr>
<td>Outpatient surgery and diagnostic and therapeutic services</td>
<td>May be performed in a hospital, an outpatient facility, or a doctor’s office</td>
</tr>
<tr>
<td>Outpatient surgery and diagnostic and therapeutic services</td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Coverage administered by Medco; open formulary — full cost of drug applies. HRA pays 100%, then you pay 20% for retail or 10% for mail order, of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Prescriptions</td>
<td></td>
</tr>
<tr>
<td>Vision and hearing</td>
<td>Only covered as part of preventive well-child care.</td>
</tr>
<tr>
<td>Vision and hearing</td>
<td></td>
</tr>
<tr>
<td>Vision and hearing</td>
<td>Hearing screenings</td>
</tr>
<tr>
<td>Vision and hearing</td>
<td>Hearing aids (for children up through the calendar year the dependent child turns age 18; limited to one hearing aid or one set of hearing aids every three calendar years, network and out of network combined)</td>
</tr>
<tr>
<td>Vision and hearing</td>
<td>Eyewear</td>
</tr>
<tr>
<td>Vision and hearing</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Vision and hearing</td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Family planning</td>
<td>(infertility treatment is subject to a $10,000 lifetime maximum)</td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td>Office visits, including infertility studies, vasectomies, tubal ligations, and artificial insemination</td>
</tr>
</tbody>
</table>

* Benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
For all benefits listed below, the HRA pays first — 100% of the covered health service. After the HRA is depleted and your deductible responsibility is satisfied, the UnitedHealthcare CDH Plan will pay as shown below unless otherwise noted in this SPD.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility treatment for diagnosis and treatment for correction of underlying conditions, including artificial insemination for diagnosed infertility, is limited to the lifetime maximum noted above (network and out of network combined)</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>In vitro fertilization, infertility drugs</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Therapy and chiropractic visits</strong></td>
<td></td>
</tr>
<tr>
<td>Physical, speech, or occupational therapy: 90 visits per calendar year combined</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Chiropractic: 26 visits per calendar year</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 20 visits per calendar year</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Durable medical equipment, prosthetics, and supplies</strong></td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 100 visits per calendar year (home health care and extended skilled nursing combined)</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Homeopathic</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 20 visits per calendar year</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Inpatient rehabilitation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Massage therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 20 visits per calendar year</td>
<td>HRA pays 100%, then you pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td><strong>Mental health and substance abuse</strong></td>
<td>First dollars are covered under UnitedHealthcare HRA. Benefits are administered by United Behavioral Health. (See “Chapter 4: Mental health and substance abuse benefits” starting on page 49 for more information.)</td>
</tr>
<tr>
<td><strong>Disease management</strong></td>
<td>Asthma, chronic obstructive pulmonary diseases, coronary artery disease, heart failure, diabetes.</td>
</tr>
<tr>
<td><strong>Member Services and website</strong></td>
<td>Member Services: number on back of your ID card or myuhc.com.</td>
</tr>
<tr>
<td><strong>Health coaches for members</strong></td>
<td>Health coach number on back of ID card or myuhc.com.</td>
</tr>
<tr>
<td><strong>Highlights</strong></td>
<td>Remaining HRA benefit dollars roll over annually for you to use for future covered health services. Flexible because no copays, no PCP required, no referrals required to see specialist. You receive a credit to your HRA if you have diabetes, asthma, coronary artery disease, or hypertension and elect to participate in and complete the Rewards for Action program on myuhc.com. See the “Rewards for Action™ program” section on page 18 for more information.</td>
</tr>
</tbody>
</table>

* Benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
Transition of care
If you are in the midst of a cycle of treatment or are in your third trimester of pregnancy when your coverage through the UnitedHealthcare CDH Plan begins, you may request that your care continue from your current provider for up to 120 days. If approved, your HRA and the coinsurance portion of the Plan will pay covered health services at the network level (subject to deductibles and other restrictions), regardless of your provider’s network status, until your pregnancy or cycle of treatment is complete. This benefit is not automatic. For more information on how to qualify, please call the number on the back of your ID card to speak with a UnitedHealthcare representative.

Out-of-network providers
The difference between the out-of-network provider’s charges and the allowed amount is not applied toward the deductible, coinsurance amounts, or out-of-pocket maximum and is your responsibility. This applies to all out-of-network services described in this SPD.

Specialists
No referrals are required to see a specialist.

Indemnity plan
If you live outside the network area and your ZIP code is within the eligibility requirements of the UnitedHealthcare Indemnity Plan, you are eligible to enroll in the UnitedHealthcare Indemnity Plan. You may choose any doctor or hospital.

- The HRA pays 100% of covered health services until exhausted, then you pay 20% of reasonable and customary fees for covered health services (10% of reasonable and customary fees for covered health services related to maternity services) after your deductible responsibility at either a network (if available) or out-of-network provider.
- The Plan pays 100% of qualifying preventive care services based on an annual exam schedule (amounts are not deducted from your HRA and there is no deductible to satisfy).
- The HRA pays 100% of prescriptions (administered by Medco), then you pay 20% for retail or 10% for mail order prescriptions, after your deductible responsibility—the full drug cost applies.
- You must submit claim forms for all expenses for Indemnity services for any provider who does not submit claim forms to UnitedHealthcare directly (see the “Claims and appeals” section on page 37 for more information).
- There is an annual coinsurance maximum of $2,000 for team member, $3,000 for team member + spouse or child(ren), and $4,000 for team member + family.

Covered health services
Health services and supplies provided for the purpose of preventing, diagnosing, or treating a sickness, injury, mental illness, substance abuse, or their symptoms are considered covered health services as described in the “What the UnitedHealthcare CDH Plan covers” section on page 20 and are not excluded in the “What is not covered” section on page 34. Experimental or investigational services and unproven services are not covered health services. (See the “Experimental, investigational, or unproven services” section on page 34 and

How the UnitedHealthcare CDH Plan works
If you live within the Plan’s network area, you may choose to use any network or out-of-network provider. Network providers have agreed to charge a discounted rate to participants in the UnitedHealthcare CDH Plan; therefore, you can make your HRA go further. In addition, the coinsurance portion of the UnitedHealthcare CDH Plan will pay a greater percentage of covered health services incurred at network providers.

If you live outside the network and your ZIP code is within the eligibility requirements for the UnitedHealthcare CDH Indemnity Plan, you are eligible to enroll in the UnitedHealthcare CDH Indemnity Plan. If you are able to receive services from a network physician or hospital, you’ll save money because network providers have agreed to charge a discounted rate to participants in the UnitedHealthcare CDH Plan; therefore, you can make your HRA go further. However, the level of benefits payable remains the same whether your care is received from a network or an out-of-network provider.

Network providers
To identify providers who participate in the UnitedHealthcare Choice Plus network associated with the UnitedHealthcare CDH Plan, access the Provider Directory Service through TeamWorks or at geoaccess.com/directoriesonline/wf.

A primary care physician selection is not required when you enroll in the UnitedHealthcare CDH Plan. You may also identify providers on your UnitedHealthcare website at myuhc.com.

Be aware that providers may discontinue their network association during the year. It is your responsibility to ensure that the provider is still a network provider before you receive services.
the “Unproven services” section on page 35 for more detail.) UnitedHealthcare has the discretion to determine what a medically necessary covered health service is, based on plan terms and established UnitedHealthcare medical policy. To be a medically necessary covered health service, UnitedHealthcare must determine that the service is medically appropriate and:

- Necessary to meet the basic health needs of the participant.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations, or governmental agencies that are accepted by the utilization review organization or claims administrator.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the participant or his or her physician.
- Demonstrated through prevailing peer-reviewed medical literature, as determined by UnitedHealthcare, to be one of the following:
  - Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed.
  - Safe with promising efficacy for treating a life-threatening sickness or condition, in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. (Life-threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

That a physician has performed or prescribed a procedure or treatment or that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is a covered health service as defined here. This definition of a covered health service relates only to the coverage under this Plan and differs from the way in which a physician engaged in the practice of medicine may define necessary care.

Covered health services must be provided:
- When the UnitedHealthcare CDH Plan is in effect
- Before the effective date of any of the individual termination conditions set forth in this SPD
- Only when the person who receives services is enrolled and meets all eligibility requirements specified in the UnitedHealthcare CDH Plan

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

**Eligible expenses**

The UnitedHealthcare CDH Plan will pay for covered health services as stated below.

Eligible expenses (allowed amounts) are based on either of the following:

- When covered health services are received from network providers, eligible expenses are the contracted fee(s) with that provider.
- When covered health services are received from out-of-network providers, the claims administrator (UnitedHealthcare) calculates eligible expenses based on available data resources of competitive fees in that geographic area that are acceptable to the claims administrator. These fees are referred to as reasonable and customary, or usual and customary, expenses. For the purpose of this Plan, reasonable and customary is defined as below or at the 90th percentile of what doctors, hospitals, and medical care providers in a specific area charge for similar services, as determined by UnitedHealthcare.

The UnitedHealthcare CDH Plan will only pay benefits for eligible expenses, which are determined solely in accordance with the applicable claims administrator’s reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the applicable claims administrator’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (CPT), a publication of the American Medical Association
- As reported by generally recognized professionals or publications
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the claims administrator accepts

**How the UnitedHealthcare CDH Plan works**

**Preventive care**

Your eligible preventive care expenses (such as annual checkups and immunizations) are covered at 100% throughout the calendar year based on the annual exam schedule. You are not required to meet your deductible first or spend your Health Reimbursement Account (HRA) dollars for network qualifying preventive care services. (See the “Preventive care services” section on page 20 for more information on qualifying preventive care.)
Health Reimbursement Account (HRA)

Wells Fargo deposits money into an HRA to cover your first-dollar health care expenses each year. You can use your HRA to pay for medical care, prescriptions, and some nontraditional health care services like massage therapy, homeopathic visits, and smoking cessation. If you don’t use it all and you stay with the UnitedHealthcare CDH Plan, it will roll over, and you’ll have more in your account to use the following year.

Amounts allocated are per coverage category and not per family member.

If you are under 65, retire, and choose to remain on a UnitedHealthcare CDH Plan, you will be moved to a pre-65 Retiree CDH Plan. Any remaining HRA dollars from your active plan will transfer to the new plan.

Please note that your HRA benefit dollars are subject to two restrictions: (1) they may only be used for covered health services as defined in this SPD, and (2) you will forfeit your HRA benefit dollars if you terminate employment for any reason or retire. In this case, the benefit dollars in your HRA will revert back to the company, unless you elect COBRA coverage. If you elect COBRA coverage, any HRA benefit dollars remaining at the time employment terminates will assist you in paying your medical expenses while COBRA coverage is in effect. In addition, if you elect another medical plan coverage option, any HRA benefit dollars remaining at the time of the plan change will no longer be available, except for covered health services incurred while you were enrolled in the UnitedHealthcare CDH Plan.

You can keep track of the benefit dollars in your HRA by going online to myuhc.com, calling the number on the back of your ID card, or checking your member statement sent to you on a monthly basis by UnitedHealthcare.

When you go to the doctor or pharmacist, show your UnitedHealthcare CDH Plan ID card and the full cost for eligible covered health services or prescriptions (as described in “Chapter 3: Prescription drug benefit” starting on page 41) under the UnitedHealthcare CDH Plan will be deducted from your HRA, until the HRA is exhausted. You do not pay a copay.

After the HRA is exhausted the following apply:

- **Your deductible responsibility.** After your HRA is exhausted, you pay the full cost for your next expenses, up to your deductible responsibility.

- **Coinsurance.** After you reach your deductible, you and Wells Fargo share costs, similar to traditional health coverage. You pay a percentage of coinsurance for your expenses, up to a maximum coinsurance amount.

- **Full coverage.** If you reach your annual coinsurance maximum, the UnitedHealthcare CDH Plan pays 100% of eligible expenses (subject to reasonable and customary charges).

Note: Mental health and substance abuse benefits are provided as a coverage option through United Behavioral Health.

HRA and deductible for midyear enrollments

If you enroll midyear in the UnitedHealthcare CDH Plan, Wells Fargo will allocate a prorated amount of benefit dollars to your HRA and you will be subject to a prorated deductible and annual coinsurance maximum under the UnitedHealthcare CDH Plan. The prorated amount is the annual amount divided by 12 and multiplied by the number of months remaining in the year from the effective date of your coverage.

Benefit dollars and deductibles for midyear changes

If you experience a midyear status change during the calendar year, resulting in an allowable change to your coverage category, your calendar year benefit dollars in your HRA, annual deductible, and annual coinsurance maximum will be adjusted.

If you extend your UnitedHealthcare CDH Plan through COBRA and you do not elect the same level of coverage you had previously, then you, your child, or your spouse may have a change to their HRA, annual deductible, and annual coinsurance for the remainder of the year.

When your coverage level is increased, your HRA benefit dollars, annual deductible, and annual out-of-pocket maximum are adjusted to your new coverage category for that calendar year, minus any amounts used in that calendar year. Any HRA benefit dollars that had rolled over from previous calendar years will remain with you.

When your coverage level decreases, your HRA benefit dollars are not adjusted to your new coverage category for that calendar year. However, your calendar year deductible is adjusted to the new coverage category for that calendar year, minus any amounts used in that calendar year. Any HRA benefit dollars that had rolled over from previous calendar years will remain with you.

If you change coverage levels anytime throughout the year and your dependents become eligible for their own individual coverage under COBRA, any charges that were incurred and applied toward the previous deductible do not count toward their new individual adjusted deductible as a result of their category change. In addition, if you elect another medical plan coverage option, any HRA benefit dollars remaining at the time
of the plan change will no longer be available, except for covered health services incurred while you were enrolled in the UnitedHealthcare CDH Plan.

Crossover claims
Beginning in 2011, the current year HRA will no longer pay claims for prior years. Prior-year claims will only apply to your prior year’s HRA balance. This means if you have a 2010 claim processed in January 2011 and your 2010 HRA balance is exhausted, you will be responsible for any patient responsibility from that claim. If there were still funds in your 2010 HRA, that claim would still pay from the 2010 HRA.

As mentioned under the “Health Reimbursement Account (HRA)” section on page 15, the HRA balance will roll forward. This means your current year claims will apply to your current year’s HRA balance first. If this balance is depleted and the prior year still has an available balance, those prior year’s funds will roll forward to assist with the current year’s claims.

Coinsurance
The UnitedHealthcare CDH Plan allows you to see any doctor or specialist or use any health care facility. However, once you’re in the coinsurance portion of the Plan, you will pay a smaller percentage of the cost for covered health services when you use network providers. The level of benefits payable remains the same under the Indemnity option, whether your care is received from a network or an out-of-network provider.

In an emergency
If you need emergency medical care and cannot arrange for care from a network provider, the UnitedHealthcare CDH Plan will pay your claims at the network level, regardless of the provider’s network status (there is no network level of benefits if you are enrolled in the Indemnity portion of the UnitedHealthcare CDH Plan).

Custom Personal Health Support
The UnitedHealthcare CDH Plan provides a program called Custom Personal Health Support designed to encourage personalized, efficient care for you and your covered dependents.

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

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

- **Admission counseling.** For upcoming inpatient hospital admissions for certain conditions, a Custom Personal Health Support health coach may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.

- **Inpatient care advocacy.** If you are hospitalized, a Custom Personal Health Support health coach will work with the facility and your physician to make sure you are getting the care you need and that your physician’s treatment plan is being carried out effectively.

- **Readmission Management.** This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted. After leaving the hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Custom Personal Health Support health coach to confirm that medications, needed equipment, or follow-up services are in place. The Custom Personal Health Support health coach will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Case Management.** Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Custom Personal Health Support health coach to discuss and share important health care information related to the participant’s specific chronic or complex condition.

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

Notifying UnitedHealthcare
It is your responsibility to ensure that UnitedHealthcare is notified before a scheduled inpatient admission, within 24 hours of an emergency admission, and before receiving certain outpatient procedures as noted below. In general, a network provider should notify UnitedHealthcare before it provides these services to you. You should notify UnitedHealthcare before receiving services from an out-of-network provider for nonemergency services.
When to notify UnitedHealthcare

The services that require you to notify UnitedHealthcare include:

• Bariatric services.
• Cardiac rehab.
• Congenital heart disease services under the Congenital Heart Disease (CHD) Resource Services program.
• Dental services related to an accident.
• Hospice.
• Infertility services.
• Inpatient admissions before planned or elective admissions and within 24 hours of an emergency admission. This includes admissions for an overnight stay in a hospital, inpatient rehabilitation facility, or skilled nursing facility.
• Maternity (birthing care services).
• Maternity services (if stay exceeds 48- or 96-hour guidelines).
• Oncology services under the Cancer Resource Services (CRS) program.
• Outpatient treatments including but not limited to:
  – Cardiac imaging or stress tests
  – CT or CAT scans (computer-aided tomography)
  – Durable medical equipment or prosthetic devices (more than $1,000 either purchase price or cumulative rental of a single item)
  – Heart catheterization
  – Home health care
  – Home IV infusion therapy
  – MRI scans (magnetic resonance imaging) or MRAs
  – Nuclear medicine services
  – PET scans
• Skilled nursing services.
• Temporomandibular joint disorder services.
• Transgender services.
• Transplant services.
• Reconstructive surgery.

Contacting UnitedHealthcare is easy; simply call the toll-free number on your ID card.

Resources to help you stay healthy

UnitedHealthcare believes in giving you the tools you need to be an educated health care consumer. To that end, UnitedHealthcare has made available several convenient educational and support services, accessible by phone and online, which can help you to:

• Take care of yourself and your family members.
• Manage a chronic health condition.
• Navigate the complexities of the health care system.

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

Registering on myuhc.com

If you have not already registered as a myuhc.com member, simply go to myuhc.com and click Register Now. Be sure to enter the required information.

myuhc.com

UnitedHealthcare’s member website, myuhc.com, provides information at your fingertips, opening the door to a wealth of health information and convenient self-service tools to meet your needs.

Health information

With myuhc.com you can:

• View your HRA balance.
• Receive personalized activation messages that are posted to your own webpage.
• Search for network providers through the online provider directory.
• Research a health condition and treatment options to get ready for a discussion with your physician.
• Access all of the content and wellness topics from health coaches.
• Complete a health assessment to identify health habits you can improve, learn about healthy lifestyle techniques, access health improvement resources, and earn a $50 incentive toward your Health Reimbursement Account.
• Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
• Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures.

**Self-service tools**
Visit [myuhc.com](http://myuhc.com) and:
• Make real-time inquiries into the status and history of your claims.
• View eligibility and UnitedHealthcare CDH Plan benefit information, including calendar year deductibles.
• View and print all of your Explanation of Benefits (EOB) statements online.
• Order a new or replacement ID card, print a temporary ID card, or check on an ID card request.

**Health improvement programs**
These web-based plans, which can be accessed through [myuhc.com](http://myuhc.com), provide you with a lifestyle action plan tailored to your risk, preferences, and lifestyle. Action plans are available for the following:
• Exercise
• Nutrition
• Stress management
• Weight management
• Tobacco cessation
• Diabetes lifestyle
• Heart health lifestyle
In addition, you will receive a personalized weekly email to help you in your personal health management.

**UnitedHealth Premium® program**
UnitedHealthcare designates network physicians and facilities as UnitedHealth Premium program physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels — quality and efficiency of care. The UnitedHealth Premium program was designed to:
• Help you make informed decisions on where to receive care.
• Provide you with decision-support resources.
• Give you access to physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium program, including how to locate a UnitedHealth Premium physician or facility, sign on to [myuhc.com](http://myuhc.com) or call the toll-free number on your ID card.

**Rewards for Action™ program**
The Rewards for Action program offers additional support through interactive specific tools. Support through the program is available for the following:
• Asthma
• Coronary artery disease
• Diabetes
• Hypertension
• Pregnancy
• Exercise
• Nutrition
• Tobacco cessation

**How the program works**
You can earn up to an additional $500 maximum annual allocation into your HRA by completing various steps in the following sections of the Rewards for Action program:
• Test your knowledge. Assess how much you know about your condition.
• Taking care of yourself. Follow treatment guidelines developed by national health organizations (e.g., the American Heart Association).
• Keep on track. Enter health data and receive instant feedback.
• Prescription monitor. Track and monitor the medications you take.
**Earning your reward**
Additional benefit dollars are allocated to your HRA as you complete each section.

<table>
<thead>
<tr>
<th>Incentive phase</th>
<th>Diabetes, asthma, coronary artery disease, hypertension</th>
<th>Tobacco cessation, pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Your Knowledge — dollars are allocated when all questions are answered correctly</td>
<td>$75</td>
<td>$30</td>
</tr>
<tr>
<td>Taking Care of Yourself — follow treatment guidelines developed by national health organizations</td>
<td>$225</td>
<td>$30 (participation encouraged)</td>
</tr>
<tr>
<td>Keep on Track — trackers used at least once a month</td>
<td>$75</td>
<td>$30</td>
</tr>
<tr>
<td>Lifestyle Credits — earn 40 credits</td>
<td>$50</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Total incentive earned</strong></td>
<td><strong>$425 maximum reward</strong></td>
<td><strong>$75 maximum reward</strong></td>
</tr>
</tbody>
</table>

**How to get started in the Rewards for Action program**
Go to your member website at myuhc.com and click the Rewards for Action link. If you have questions or need assistance with the online assessment, please call the number on the back of your ID card.

**Who is eligible for the Rewards for Action program?**
You, your spouse, and any dependent age 18 years and over who are covered under the UnitedHealthcare CDH Plan may participate in this program.

*Note: All assessments are kept confidential and your participation in this assessment will not affect your benefits or eligibility for benefits in any way.*

**Health coaches**
Health coaches are available through a toll-free telephone service that puts you in immediate contact with an experienced health coach any time, 24 hours a day, 7 days a week. Health coaches can provide health information for routine or urgent health concerns. Call anytime you want to learn more about:

- A recent diagnosis
- A minor sickness or injury
- Men's, women's, and children's wellness
- How to take prescription drugs safely
- Self-care tips and treatment options
- Healthy living habits
- Any other health-related topic

Depending on your situation, you may receive follow-up calls from symptom support, acute care, or complex care nurses.

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

*Note: If you have a medical emergency, call 911 instead of calling a health coach.*

**Disease management**
UnitedHealthcare provides responsive disease management programs that identify, assess, and support members with specific chronic conditions. Chronic condition support is available for:

- Asthma
- Diabetes
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Comorbidity management of depression
- End-stage renal disease (ESRD)
- Hypertension

If you are interested in one of these programs, you may request information from a health coach.
Maternity support program
If you are pregnant and enrolled in the UnitedHealthcare CDH Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

• A free copy of The Healthy Pregnancy Guide
• Pregnancy assessment to identify your special needs
• A phone call from a nurse approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations, and more
• A copy of an available publication, for example, Healthy Baby Book, which focuses on the first two years of life

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

As a program participant, you can call anytime, 24 hours a day, 7 days a week, with any questions or concerns you might have.

HealtheNotes campaigns
To help support you in your health care decisions, UnitedHealthcare may send you and your covered dependents materials focused on the following topics:

• Your health care experience
• Your health and wellness
• Value for your health care dollar

What the UnitedHealthcare CDH Plan covers
The UnitedHealthcare CDH Plan covers certain treatments for illness, injury, and pregnancy. (See the “Covered health services” section on page 13 for more detail) Coverage is not necessarily limited to services and supplies described in this section — but do not assume an unlisted service is covered. If you have questions about coverage, call UnitedHealthcare.

These services are subject to the limitations, exclusions, and procedures described in this SPD. When more than one definition or provision applies to a service, the most restrictive applies and exclusions take precedence over general benefits descriptions.

The Plan only covers care provided by health care professionals or facilities licensed, certified, or otherwise qualified under state law to provide health care services and acting within the scope of their licensureship or certification.

Preventive care services
The Plan covers in-network, eligible preventive care services at 100%. Expenses are not deducted from your HRA, and you do not need to satisfy the deductible. When using out-of-network providers, eligible preventive care services are not subject to the out-of-network deductible, your HRA pays 100%, then you pay 40% of the UnitedHealthcare allowed amount.

In order for a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines. Many of the guidelines take into account gender, age, and your or your family’s medical history.

Preventive care services for children
As recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics, the types of services for children covered as preventive care services include but are not limited to:

• Well-baby care physical exams
• Well-child care physical exams
• Vision and hearing screenings
• Developmental assessments
• Screening for depression and obesity

Routine vaccines
As recommended by the Center for Disease Control’s Advisory Committee on Immunization Practices, the types of routine vaccines covered as preventive care services include but are not limited to:

• Routine childhood immunizations such as diphtheria, tetanus, pertussis, polio, chicken pox, measles, mumps, rubella, hepatitis A and B, pneumococcal, meningococcal, rotavirus, human papillomavirus, flu
• Routine vaccinations for adults such as flu, pneumococcal, tetanus, diphtheria, Zoster

Preventive care services for adults
As recommended by the U.S. Preventive Services Task Force, the types of services covered as preventive care services for adults include but are not limited to the following services that have a current rating of A or B:

• Adult routine physical exams
• Routine screenings such as blood pressure, cholesterol, diabetes
• Routine screenings such as mammography, colonoscopy, pap smear, PSA test
• Routine gynecological exams
• Bone density tests
• Routine prenatal and postnatal care and exams
• Screening for depression and obesity

Your provider will inform the Plan what services you received when the provider submits the claim to the Plan for processing. If the claim is coded as an eligible preventive care service with a routine diagnosis code, the claim will be paid as a preventive care service.

Services not considered preventive care services:
• Services that are not recommended by one of several federal government or independent agencies responsible for the development and monitoring of various U.S. preventive care guidelines.
• Although recommended by one of several government or independent agencies responsible for the development and monitoring of U.S. preventive care guidelines, services that do not follow the government or independent agency’s age, gender, or family history recommended guidelines.
• Services the provider submits to the Plan coded as nonroutine, which may include:
  – Office visits, screenings, lab work, tests, or procedures to diagnose a condition, treat a specific illness, or monitor an existing condition.
  – Additional office visits, lab works, tests, or procedures recommended or required as a result of a preventive care visit, lab work, test, or procedure.
  – Office visits, screenings, lab work, tests, or procedures if a condition or diagnosis is detected.
  – Part of the services received that the provider submits to the Plan coded as nonroutine (i.e., office visit, lab work, tests, or procedures).

If you receive eligible preventive care services at the same time you receive other nonpreventive care services, certain services may be paid with HRA dollars, subject to the annual deductible or coinsurance. For example, if you see your provider for a recurring medical problem, but also receive an eligible preventive care service, the provider may submit the claim as a nonpreventive care service. However, the provider may submit separate claims for the preventive and nonpreventive services or treatments.

If the primary purpose of your visit is for preventive care services (e.g., an annual physical exam), but you also discuss other health problems during the visit (e.g., a recurring medical problem), your provider may submit the claim as an eligible preventive care service or the provider may submit separate claims for the preventive and nonpreventive services or treatments.

If you have questions about how claims for your office visit, screenings, lab work, tests, or procedures will be submitted to the Plan, talk to your provider about the type of care you receive or are recommended to receive before the claim is submitted to the Plan. Once the claim is submitted to the Plan, the claim will be processed based on how your provider coded the claim (i.e., services coded by your provider as routine services will be processed as routine services).

For additional information on preventive care coverage under the Plan, visit the Plan’s website or call UnitedHealthcare’s Member Services department.

Other covered services
The following is a list of items that are included as covered health services under the Plan and will count toward satisfaction of your calendar year deductible.

Acupuncture
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers services of a licensed or certified physician, chiropractor, or acupuncturist acting within the scope of that license or certification, limited to 26 visits per calendar year, network and out-of-network combined. Services must be needed for pain therapy, provided that another method of pain management has failed.

Covered health services include treatment of nausea as a result of the following:
• Chemotherapy
• Pregnancy
• Postoperative procedures

For exceptions, refer to the “What is not covered” section on page 34.

Ambulance
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance.

• Ambulance service to and from a local hospital required for stabilization and initiation of medical treatment as provided under the direction of a physician in an emergency situation.
• Air ambulance to the nearest facility qualified to give the required treatment when ground ambulance transportation is not medically appropriate because of the distance involved or because the member has an unstable condition requiring medical supervision and rapid transport. This would include
transportation, if needed, in a foreign country to a more appropriate facility.

- Ambulance transport from hospital to next level of acute care services — for example, a skilled nursing facility or rehabilitation facility (does not include custodial placement).
- Ambulance transport from skilled nursing facility or rehabilitation facility to another facility or hospital for tests or diagnostics when such tests or diagnostics cannot be rendered at the facility.

Not covered:
- Ambulance services not listed above
- Transportation services that are not necessary for basic or advanced life support
- Transportation services that are mainly for your convenience

Also refer to the “What is not covered” section on page 34.

**Bariatric services**
See the “Morbid obesity” section on page 27.

**Chiropractic care**
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan provides benefits for spinal treatment (including chiropractic and osteopathic manipulative therapy) when provided by a spinal treatment provider in the provider’s office. Benefits include diagnosis and related services and are limited to one visit and treatment per day, 26 visits per calendar year, network and out-of-network combined.

Not covered:
- Therapy, service, or supply, including but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, such as maintaining a level of functioning or preventing a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment to treat an illness such as asthma or allergies

Also refer to the “What is not covered” section on page 34.

**Dental care**
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers certain medically necessary hospital services (see the “Covered health services” section on page 13) for dental care, limited to charges incurred by a covered person who:
- Is a child under age five
- Is a child between the ages of five and 12 and where either of the following is true:
  - Care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful
  - Extensive amounts of restorative care, exceeding four appointments, are required
- Is severely disabled
- Has one of the conditions listed below, requiring hospitalization or general anesthesia for dental care treatment:
  - Respiratory illnesses
  - Cardiac conditions
  - Bleeding disorders
  - Severe risk of compromised airway
  - The need for extensive procedures that prevent an oral surgeon from providing general anesthesia in the office setting, regardless of age
  - Psychological barriers to receiving dental care, regardless of age

The above coverage is limited to facility and anesthesia charges. Oral surgeon or dentist professional fees are not covered. Covered health services are determined based on established medical policies, which are subject to periodic review and modification by the medical directors.

The UnitedHealthcare CDH Plan also covers:
- Treatment from a physician or dentist for an accidental injury to sound natural teeth when performed within 12 months from the date of injury (UnitedHealthcare must be notified before receiving services); coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth that result from biting or chewing
- Treatment of cleft lip and palate for a dependent child under age 18
- Orthognathic surgery that meets the reconstructive surgery provisions on page 30 and the UnitedHealthcare criteria
- Dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia necessary to:
  - Prepare for transplant
  - Initiate immunosuppressives
– Diagnose cancer
– Directly treat current instance of cancer

Not covered:
(Regardless of whether medical or dental in nature)
• Dental implants and all associated expenses
• Dental braces or orthodontia services and all associated expenses
• Dental x-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia, except as previously noted
• Oral appliances except as needed for medical conditions affecting temporomandibular joint dysfunction (TMJ). See the “Temporomandibular joint dysfunction (TMJ)” section on page 31 for more information.
• Oral surgery, and all associated expenses, including hospitalizations and anesthesia, except as previously noted
• Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums, and all associated expenses, including hospitalizations and anesthesia, except as previously noted
• Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly, and all associated expenses, including hospitalizations and anesthesia, except as previously noted

Also, refer to the “What is not covered” section on page 34.

Durable medical equipment, supplies, and prosthetics

Durable medical equipment and supplies
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The Plan provides benefits for durable medical equipment and supplies that meet each of the following criteria:
• Ordered, prescribed, or provided by a physician for outpatient use for the patient’s diagnosed condition
• Used for medical purposes
• Equipment, appliances, or devices that are not consumable or disposable
• Not of use to a person in the absence of a disease or disability
• For orthotic appliances and devices, that the items must be custom manufactured or custom fitted to the patient for diagnosed condition

UnitedHealthcare must be notified before obtaining any single item of durable medical equipment or prosthetic device that costs more than $1,000 (either purchase price or cumulative rental of a single item).

If more than one piece of durable medical equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment. The UnitedHealthcare CDH Plan provides benefits for a single unit of durable medical equipment (for example, one insulin pump), and provides repair for that unit. Benefits are provided for replacement of a type of durable medical equipment once every three years, unless there is a change in the covered person’s medical condition that requires repair or replacement sooner (e.g., due to growth of a dependent child).

Covered durable medical equipment:
• Wheelchair
• Standard hospital bed
• Delivery pumps for tube feeding
• Shoe orthotics for foot amputees only
• Insulin pumps
• Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
• Braces to treat curvature of the spine
• Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions
• Oxygen concentrator units and equipment rental to administer oxygen
• Covered supplies:
  – Surgical dressings, casts, splints, trusses, crutches, and noncorrective contact lens bandage(s)
  – Contraceptive devices, including intrauterine devices, diaphragms, and implants
  – Ostomy supplies (pouches, face plates, and belts; irrigation sleeves, bags, and catheters; and skin barriers)
  – Burn garments

Prosthetics
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers prosthetic devices that replace a limb or body part, including artificial limbs and artificial eyes. It also covers breast prosthesis as required by the Women’s Health and Cancer Rights Act of 1998. UnitedHealthcare must be notified before obtaining any single item of durable medical equipment or
prosthetic device that costs more than $1,000 (either purchase price or cumulative rental of a single item). If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device as determined by UnitedHealthcare. The prosthetic device must be ordered or provided by or under the direction of a physician. The Plan provides benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every three years.

Not covered:

• Supplies, equipment, and similar incidental services and supplies for personal comfort, regardless of medical need, including but not limited to air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers, devices and computers to assist in communication and speech, home remodeling to accommodate a health need (such as ramps and swimming pools), and vehicle enhancements

• Cranial bands and cranial banding

• Items that can be obtained without a prescription or physician’s order

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

• Prescribed or nonprescribed medical supplies and disposable supplies, including elastic stockings, ace bandages, gauze, and dressings

• Tubings, nasal cannulas, connectors, and masks, except when used with durable medical equipment

• Appliances for snoring

• Eye glasses or contact lenses except for the first purchase following cataract surgery

• Fitting charge for eye glasses, contact lenses, or hearing aids

• Hearing aids or assisted hearing devices, except as noted under the “Hearing aids” section on this page

• Orthotics (except as noted above)

• Oral or dental prosthesis

Also, refer to the “What is not covered” section on page 34.

Emergency care

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers emergency care services if, in the judgment of a reasonable person, immediate care and treatment is required, generally within 24 hours of onset, to avoid jeopardy to life or health. If these criteria are met, the following will be covered:

• Accidental injury and other medical emergencies treated in an emergency room

• Services received at an urgent care center to treat urgent health care needs, if they are a covered expense

For exceptions, refer to the “What is not covered” section on page 34.

Family planning

See the “Infertility and fertility treatment” section on page 27.

Hearing aids

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers hearing aids up through the calendar year in which the child turns age 18 and up to one hearing aid or one set of hearing aids every three calendar years.

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Home health care

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. UnitedHealthcare notification is required before receiving home health care. The UnitedHealthcare CDH Plan pays for covered health services for treatment of a disease or injury in the patient’s home instead of a hospital or skilled nursing facility. The charge must be made by a home health care agency. Home health care must be prescribed by a physician and given under a home health care plan in the patient’s home. Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, teaching, and rehabilitation services provided by licensed technical or professional medical personnel to obtain a medical outcome and provide for the patient’s safety.

Coverage is limited to 100 visits (combined with extended nursing skills) by a home health care professional, network and out-of-network combined. One visit is equal to four consecutive hours in a 24-hour period.
The UnitedHealthcare CDH Plan covers the following home health care expenses (up to the UnitedHealthcare CDH Plan maximums):

- Part-time or occasional care by a licensed nurse
- Intermittent home health aide services
- Services of a medical social worker
- Physical, occupational, speech, and inhalation therapy
- Medical supplies and medicines prescribed by a physician
- Services of a nutritionist

Not covered:

- Custodial care, maintenance care, or home health care delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. Custodial or maintenance care includes but is not limited to help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. This type of care is primarily required to meet the patient’s personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence. The care does not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- Services provided by a family member or a person living in your home.
- Private duty nursing (see the “Extended skilled nursing care” section below for more information).

Also, refer to the “What is not covered” section on page 34.

Extended skilled nursing care

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Extended skilled nursing care is defined as the use of skilled nursing services delivered or supervised by a registered nurse (RN) or licensed practical nurse (LPN) to obtain the specified medical outcome and provide for the safety of the patient. To be covered under the Plan:

- An attending physician must order extended skilled nursing care.
- Certification of the RN or LPN providing the care is required.
- The Plan, in its sole discretion, must determine that the extended skilled nursing care is medically necessary.

Benefits are limited to 100 visits (combined network & out of network) per calendar year combined with home health care. Each 24-hour visit (or shifts of up to 24-hour visits) equal one visit and count towards the 100 combined visits. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit towards the 100 visit limitation (combined with home health care).

Services provided under the following circumstances will be considered extended skilled nursing services:

- Transition of the covered person from an inpatient setting to home.
- The covered person becomes acutely ill and the additional skilled nursing care will prevent a hospital admission.
- The covered person meets the clinical criteria for confinement in a skilled nursing facility, but a skilled nursing facility bed is not available. In this situation, additional skilled nursing may be provided until a skilled nursing facility bed becomes available.
- The covered person is on a ventilator or is dependent on continuous positive airway pressure due to respiratory insufficiency at home.

Not covered:

- Nursing care that does not require the education, training, and technical skills of an RN or LPN.
- Nursing care provided for skilled observation.
- Nursing care provided while the covered person is an inpatient in a hospital or health care facility.
- Nursing care to administer routine maintenance medications or oral medications, except where law requires an RN or LPN to administer medicines.
- Custodial care for daily life activities such as but not limited to:
  - Transportation
  - Meal preparation
  - Vital sign charting
  - Companionship activities
  - Bathing
  - Feeding
  - Personal grooming
  - Dressing
  - Toileting
  - Getting in or out of bed or a chair
Services that can be safely and effectively performed by a nonmedical person or self-administered without the direct supervision of a licensed nurse. The unavailability of a person to provide an unskilled service does not allow for coverage for a nurse to provide unskilled services.

Also, refer to the “What is not covered” section on page 34.

**Homeopathic services**

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers up to a maximum of 20 visits per calendar year, network and out-of-network combined.

For exceptions, refer to the “What is not covered” section on page 34.

**Hospice care**

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. You must notify UnitedHealthcare before you receive services. The Plan covers hospice care that is recommended by a physician. Hospice care is an integrated program that provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill and has less than six months to live. Benefits are available when hospice care is received from a licensed hospice agency. The UnitedHealthcare CDH Plan covers the following services:

- Palliative care
- Inpatient care
- In-home health care services, including nursing care, use of medical equipment, wheelchair and bed rental, and home health aide care
- Physician services
- Emotional support services
- Bereavement counseling for covered family members while the covered person is receiving hospice care

For exceptions, refer to the “What is not covered” section on page 34.

**Hospital inpatient services**

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. You must contact UnitedHealthcare for preauthorization before receiving the following services:

- Semiprivate room and board
- Intensive care and cardiac care
- Miscellaneous medically appropriate hospital services and supplies, including operating room, except as noted under “Not covered” in this section
- X-ray and lab services, drugs, and anesthetics and their administration
- Physician and surgeon services received during the inpatient hospital stay
  - If you use an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
  - Noncontracted assistant surgeon fees in a nonemergency situation are considered at 50% of the allowed fee for the primary surgeon, as determined by UnitedHealthcare. The difference between the amount charged and the amount paid by UnitedHealthcare is the team member’s responsibility.
- Blood and blood derivatives (unless donated), including charges for presurgical self-blood donations
- Christian Science services when provided by a Christian Science practitioner or a Christian Science nurse for charges while confined for healing purposes in a Christian Science sanitarium, for a condition that would require a person of another faith to enter an acute care hospital

Not covered:

- Admission for diagnostic tests that can be performed on an outpatient basis
- Comfort or convenience items such as television, telephone, beauty or barber service, or guest service
- Late charges for less than a full day of hospital confinement, if for patient convenience
- Private-duty nursing in a hospital (see the “Extended skilled nursing care” section on page 25 for more information)
- Private room charges when facility has a semiprivate room available
- Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery
- Telephone toll billings for Christian Science Services

Also, refer to the “What is not covered” section on page 34.
Infertility and fertility treatment
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Infertility treatment is limited to a lifetime maximum benefit of $10,000 (network and out-of-network combined) for diagnosis and treatment for correction of underlying conditions. This includes artificial insemination for diagnosed infertility also.

Not covered:
- Infertility prescription drugs
- In vitro fertilization, GIFT, and ZIFT and related charges are specifically excluded from coverage
- Health services and associated expenses for infertility treatments, except artificial insemination
- A surrogate’s pregnancy on your behalf and related obstetric and maternity benefits
- Reversal of voluntary sterilization and any related charges
- Treatment of infertility after reversal of voluntary sterilization and any related charges
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance or storage of sperm, ovum, or frozen embryos

Also, refer to the “What is not covered” section on page 34.

Massage therapy
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Massage therapy is covered when determined to be medically necessary by a physician, up to a maximum 20 visits per calendar year, network and out-of-network combined.

For exceptions, refer to the “What is not covered” section on page 34.

Maternity care
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Benefits for pregnancy will be paid at a higher level than benefits for any other condition, sickness, or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The UnitedHealthcare CDH Plan will pay benefits for the covered mother and the newborn (the child must be added to your coverage through Wells Fargo within 60 days of birth — refer to “Chapter 1: An introduction to your benefits” in your Benefits Book) for an inpatient stay while both are in the hospital, as follows:
- 48 hours from time of delivery for the mother and newborn child following a normal delivery
- 96 hours from time of delivery for the mother and newborn child following a Cesarean section delivery

Your provider does not need authorization from the UnitedHealthcare CDH Plan to prescribe a hospital stay of this length. However, if your provider determines that a longer stay is required, you must notify UnitedHealthcare as soon as reasonably possible. If you don’t notify UnitedHealthcare that the inpatient stay will be extended, benefits for the extended stay will be reduced.

If the mother agrees, the attending provider may discharge the mother, the newborn child, or both earlier than these minimum stays.

In-home midwives, birthing centers, and fetal monitors (including intrauterine devices) are covered with UnitedHealthcare approval.

Refer to the “Preventive care services” section on page 20 for information on newborn immunization and routine care. You must add your child to coverage by notifying the HR Service Center within 60 days of the date of birth to receive benefits for any charges incurred by the newborn after the mother has been discharged from her maternity stay.

For exceptions, refer to the “What is not covered” section on page 34.

Morbid obesity
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. For individuals with a body mass index of 35 or greater, coverage may be available for gastric bypass or lap band surgery if specific criteria are met.

Enrollment for the bariatric services program must be initiated with Bariatric Resource Services before receiving services. Covered participants seeking coverage for bariatric services should notify Bariatric Resource Services as soon as possible by calling 1-888-936-7246 to determine if they meet criteria to enroll in the program. This is a comprehensive program that requires patients meet specific selection criteria, as established in the UnitedHealthcare Bariatric Surgery medical policy, and also requires presurgery psychological evaluation. Compliance with all components of the bariatric services program is required.
After the member is enrolled, the United Behavioral Health Care Advocate from the Bariatric Outreach Unit will coordinate ongoing psychological care with United Behavioral Health network providers and a designated facility. The mental health benefits provisions apply to any psychological care received.

All bariatric services, including nutritional counseling, must be received at a designated Center of Excellence facility to be covered. Any services received outside of a designated facility are not covered and no benefits will be paid. A designated Center of Excellence facility may or may not be located within your geographic area. Depending on the location of the designated facility, you may be eligible for reimbursement of a portion of transportation and lodging. The services described in the “Transportation and lodging for bariatric services, transplants, transgender surgery, cancer, and CHD” section on page 34 are covered health services only in connection with the program’s morbid obesity bariatric services received at a designated facility after enrollment in the program. A $250 credit will be applied to your out-of-pocket expenses when you use a designated facility.

A designated facility has entered into an agreement with UnitedHealthcare or with an organization contracting on behalf of the Plan, to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by UnitedHealthcare. That a facility is considered in-network under the Plan does not mean it is a designated facility.

Not covered:

- Services received from providers who are not part of the UnitedHealthcare Centers of Excellence program for bariatric services
- All other weight-loss-related services, supplies, or treatments, including weight loss programs, health clubs, or spas
- Experimental, investigational, or unproven services
- Excess skin removal after successful weight loss, regardless of need
- Food, food substitutes, or food supplements of any kind (diabetic, low fat, cholesterol, etc.)
- Megavitamin and nutrition-based therapy
- Oral vitamins and oral minerals
- Repeat weight loss surgery, meaning a second or subsequent procedure performed regardless of type of weight loss surgery performed and regardless of coverage at the time of the previous procedure

Also, refer to the “What is not covered” section on page 34.

Nutritionists

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The Plan will pay for nutritional counseling provided in a physician’s office by an appropriately licensed nutritionist or health care professional when education is required for a disease in which patient self-management is an important component of treatment and when a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required. Some examples of such medical conditions include:

- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (PKU, a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

For exceptions, refer to the “What is not covered” section on page 34.

Nutritional formulas

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers nutritional formulas only when used as the definitive treatment of an inborn metabolic disorder, such as PKU.

Not covered:

- Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, and electrolyte supplements (except when used as the definitive treatment of an inborn metabolic disorder, such as PKU)
- Diets for weight control or treatment of obesity (including liquid diets or food)
- Food, food substitutes, or food supplements of any kind (diabetic, low fat, cholesterol, infant formula, etc.)
- Over-the-counter oral vitamins and oral minerals
- Megavitamin and nutrition-based therapy
Nutritional counseling for either individuals or groups (except as stated above), including weight loss programs, health clubs, and spa programs

Also, refer to the “What is not covered” section on page 34.

Outpatient surgery and diagnostic and therapeutic services

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers services received on an outpatient basis at a hospital or alternate facility including:

• Scheduled surgery, anesthesia, and related services
  – When more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
  – Noncontracted assistant surgeon fees in a nonemergency situation are considered at 50% of the allowed fee for the primary surgeon, as determined by UnitedHealthcare. The difference between the amount charged and the amount paid by UnitedHealthcare is the team member’s responsibility.

• Scopic procedures — outpatient diagnostic and therapeutic*
  – Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.
  – Benefits do not include inpatient surgical scopic procedures. Benefits for inpatient surgical scopic procedures are covered in the “Hospital inpatient services” section on page 26.

• Radiation and chemotherapy

• Kidney dialysis (both hemodialysis and peritoneal dialysis)

• Lab

• X-ray*

You must contact UnitedHealthcare before receiving:

• CT or CAT scans (computer-aided tomography)*

• Imaging cardiac stress tests

• MRI scans (magnetic resonance imaging)*

• Mammography testing

• CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services* (in-network physicians are required to get a high tech radiology notification)

• Covered health services include medical education services that are provided on an outpatient basis by appropriately licensed or registered health care professionals when education is required for a disease in which patient self-management is an important component of treatment, and where a knowledge deficit exists regarding the disease for which the intervention of a trained health professional is required.

* When more than one diagnostic procedure is performed within the same diagnostic family on the same session, one procedure will be considered at 100% of the eligible expense and the other procedures will be considered at 50% of the eligible expense.

For exceptions, refer to the “What is not covered” section on page 34.

Physician services

After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Physician services include:

• Allergy testing, serum, and injections

• Inpatient hospital or facility visits

• Office visits for illness

• Outpatient hospital or facility visits

• Charges for telephone, email, and internet consultation, as well as telemedicine

• Preventive care

• Surgery
  – If you use an out-of-network provider and more than one surgical procedure is performed, the eligible expense for the primary procedure will be considered at 100%; each subsequent procedure will be considered at 50% of the eligible expense.
  – Noncontracted assistant surgeon fees in a nonemergency situation are considered at 50% of the allowed fee for the primary surgeon, as determined by UnitedHealthcare. The difference between the amount charged and the amount paid by UnitedHealthcare is the team member’s responsibility.

• Treatment of eye disease

Not covered:

• Charges for a physician who does not perform a service but is on call

• Routine physical examinations not required for health reasons, including but not limited to employment, insurance, government license, court-ordered, forensic, or custodial evaluations

• Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the “Hospital inpatient services” section on page 26
• Surgery that is intended to allow you to see better without glasses or other vision correction services, including radial keratotomy, laser, or other refractive eye surgery
• Vision therapy or eye exercise
Also, refer to the “What is not covered” section on page 34.

Reconstructive surgery
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers certain reconstructive procedures when preauthorized by UnitedHealthcare (contact UnitedHealthcare). Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part to address the following:
• Prompt repair of accidental injury that occurs while covered under the UnitedHealthcare CDH Plan
• To improve function of a malformed body part
• To correct a defect caused by infection or disease
The UnitedHealthcare CDH Plan also covers the cost of postmastectomy reconstructive surgery performed on you or your eligible covered dependents in a manner determined in consultation with the attending physician and patient for:
• Reconstruction of the breast on which the mastectomy was performed
• Surgery and reconstruction of the other breast to produce a symmetrical appearance
• Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas
All of the UnitedHealthcare CDH Plan provisions continue to apply. If you have any questions regarding postmastectomy reconstructive surgery coverage, contact UnitedHealthcare customer service.

Not covered:
• Cosmetic procedures including but not limited to surgery, pharmacological regimens, nutritional procedures or treatments, scar or tattoo removal or revision procedures, or skin abrasion
• Liposuction
• Removal of excess skin after weight loss, regardless of need
• Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure
• Services related to teeth, the root structure of teeth, or supporting bone and tissue; see the “Dental care” section on page 22
Also, refer to the “What is not covered” section on page 34.

Skilled nursing facility
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. UnitedHealthcare notification is required before receiving services. The UnitedHealthcare CDH Plan covers services for an inpatient stay in a skilled nursing facility or acute inpatient rehabilitation facility. Benefits are limited to 100 days per calendar year for skilled nursing. There are no limits for acute inpatient rehabilitation.

Benefits are available for:
• Services and supplies received during the inpatient stay
• Room and board in a semiprivate room (a room with two or more beds)

Skilled nursing provides benefits if you are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services that are less than those of a general acute hospital but greater than those available in the home setting. You are expected to improve to a predictable level of recovery.

Benefits are available only when skilled nursing, rehabilitation services, or both are needed on a daily basis. Benefits are not available when these services are required intermittently (such as physical therapy three times a week).

Not covered:
• Custodial, domiciliary, or maintenance care (including administration of internal feeds), even when ordered by a physician. Custodial, domiciliary, or maintenance care includes but is not limited to help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. It is primarily required to meet the patient’s personal needs or maintain a level of function, as opposed to improving that function to allow for a more independent existence.
• Services that do not require continued administration by trained medical personnel to be delivered safely and effectively.
• Private duty nursing (see the “Extended skilled nursing care” section on page 25 for more information)
Also, refer to the “What is not covered” section on page 34.

**Temporomandibular joint dysfunction (TMJ)**
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. With preauthorization, the UnitedHealthcare CDH Plan covers treatment of medical conditions affecting the temporomandibular joint when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a congenital anomaly, developmental defect, or pathology.

Not covered:
- Charges for services that are dental in nature

**Therapy or short-term rehabilitation**
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan provides benefits for the following types of outpatient services:
- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy (preauthorization is required, contact UnitedHealthcare)

The services must be performed by a licensed therapy provider, under the direction of a physician. Benefits are limited to 90 visits of speech therapy, occupational therapy, and physical therapy combined, in network and out of network, per calendar year.

Rehabilitation services are only covered to restore previously attained function lost due to injury or illness. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. After an initial evaluation visit, chart notes and an updated treatment plan including a progress report with measurable objectives and how those objectives have been or will be met are necessary to validate progress and the need for future visits whether the provider is in or out of network.

Habiliative services rendered for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal motor development in children, per established medical policy. Habilitative speech therapy, physical therapy, and occupational therapy are available for children up through the end of the calendar year in which they turn 18. Prior authorization is required. Your network provider and facility will obtain authorization for you.

After an initial evaluation visit, chart notes and an updated treatment plan including a progress report with measurable objectives and how those objectives have been or will be met are necessary to validate progress and the need for future visits, whether the provider is in- or out-of-network.

Not covered:
- Therapy that has not been approved by UnitedHealthcare or that does not meet the UnitedHealthcare criteria guidelines
- Therapy for voice modulation, articulation, or similar training (including to teach people to speak another language)
- Speech therapy to treat stuttering, stammering, or the elimination of a lisp
- Habilitative therapy beyond the age limit of the calendar year in which the child turns age 18
- Therapy to improve general physical condition or performance
- Speech therapy that has not been approved by UnitedHealthcare
- Any type of therapy, service, or supply for the treatment of a condition when the therapy, service, or supply ceases to be therapeutic treatment; therapy is excluded if it is administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring, or if objective measurable progress is not being documented
- Hippotherapy
- Prolotherapy
- Eye exercise or vision therapy

Also, refer to the “What is not covered” section on page 34.

**Transgender services**
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan covers many of the charges incurred for transgender surgery (also known as sex reassignment surgery) for covered persons who meet all of the conditions for coverage listed below. Transgender surgery benefits are limited to one surgery per covered person per lifetime.

For transgender surgery benefits, the criteria for diagnosis and treatment are based on the guidelines set forth by the World Professional Association for Transgender Health (WPATH), formerly known as The Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA).
Covered expenses. These include:

- Pre- and postsurgical hormone therapy covered under the pharmacy benefit
- Surgery, subject to the requirements outlined under “Conditions for coverage” below

Conditions for coverage. To receive benefits, the patient must:

- Be at least 18 years of age
- Have undergone continuous hormonal therapy — usually for 12 months — if no medical contraindication
- Have undergone 12 months of successful, continuous, full-time, real-life experience
- If required by the mental health professional, have participated regularly in psychotherapy throughout the real-life experience
- Show a demonstrable knowledge of the cost, required lengths of hospitalizations, and likely complications
- Be aware of postsurgical rehabilitation requirements of various surgical approaches
- Undergo psychotherapy both before and after the surgery

Surgery is subject to the conditions listed below:

- The surgery must be performed by a qualified provider, as determined by UnitedHealthcare.
- The treatment plan must conform to WPATH standards.
- You or your physician must notify UnitedHealthcare for any surgery.

You must notify UnitedHealthcare as soon as the possibility of a transgender surgical benefit arises. If you don’t notify UnitedHealthcare, benefits paid by the UnitedHealthcare CDH Plan will be subject to a 25% increase in your required coinsurance amount.

Transgender surgery exclusions. These include:

- Any transgender surgery or related services for a covered person who does not meet all the conditions for coverage listed above
- Cosmetic surgery or other services performed solely for beautification or to improve appearance, such as breast augmentation or reduction, tracheal shaving, and electrolysis; this exclusion does not apply to mastectomy and mastectomy scar revision for a female to male transition as noted above
- Charges for services or supplies not listed as covered expenses above
- Charges for services or supplies that are not medically necessary

Transgender surgery travel expenses. Refer to the “Transportation and lodging for bariatric services, transplants, transgender surgery, cancer, and CHD” section on page 34 for information about covered travel expenses.

Voluntary transplant program

Organ, bone marrow, and tissue transplants. After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Covered services and supplies for the following organ or tissue transplants are payable under the Plan when ordered by a physician. UnitedHealthcare must be notified at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- Evaluation.
- Donor search.
- Organ procurement or tissue harvest.
- Organ transplants.
- Donor charges for organ or tissue transplants. In case of an organ or tissue transplant, donor charges are considered covered health services only if the recipient is a covered person under the Plan. If the recipient is not a covered person, no benefits are payable for donor charges.
- The search for bone marrow or stem cell from a donor who is not biologically related to the patient is not considered a covered health service unless the search is made in connection with a transplant procedure arranged by a designated facility.

If a qualified procedure is a covered health service and performed at a designated facility, the medical care and treatment provisions and the transportation and lodging provisions apply. A $250 credit will be applied to your out-of-pocket expenses when you use a designated facility.

Qualified procedures include:

- Heart
- Heart and lung
- Liver
- Lung (single or double)
- Pancreas for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session, or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
• Kidney
• Liver and kidney
• Intestine
• Liver and intestine
• Cornea — you are not required to notify UnitedHealthcare of a cornea transplant, nor is the cornea transplant required to be performed at a designated facility
• Bone marrow and stem cell
• Pancreas
• Kidney and pancreas
• Other transplant procedures when UnitedHealthcare determines that it is medically appropriate to perform the procedure at a designated facility
• Medical care and treatment — the covered expenses for services provided in connection with the transplant procedure include:
  – Pretransplant evaluation for one of the procedures listed above
  – Organ acquisition and procurement
  – Hospital and physician fees
  – Transplant procedures
  – Follow-up care for a period up to one year after the transplant
  – Search for bone marrow and stem cell from a donor who is not biologically related to the patient
A designated facility has entered into an agreement with UnitedHealthcare or with an organization contracting on behalf of the Plan to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions as determined by UnitedHealthcare. The fact that a hospital is considered in-network under the Plan does not mean that it is a designated facility.
Coverage is limited to two transplant procedures for the same condition per person.
Also refer to the “What is not covered” and the “Transportation and lodging for bariatric services, transplants, transgender surgery, cancer, and CHD” sections on page 34.

Cancer Resource Services
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. The UnitedHealthcare CDH Plan pays benefits for oncology services provided by designated facilities participating in the Cancer Resource Services (CRS) program. For oncology services and supplies to be considered covered health services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. However, services determined to be experimental, investigational, or unproven by UnitedHealthcare will not be covered even if recommended by a provider who is part of the CRS program.
You do not need to visit a designated facility to receive benefits for a cancer-related treatment; however, to receive benefits under the CRS program, you must contact CRS toll-free at 1-866-936-6002 before obtaining covered health services. The UnitedHealthcare CDH Plan will only pay benefits under the CRS program if CRS provides the proper notification to the designated facility or provider performing the services (even if you self-refer to a provider in that network).

If you or a covered dependent has cancer, you may:
• Be referred to CRS by a Custom Personal Health Support Nurse
• Call CRS toll-free at 1-866-936-6002
• Visit myoptumhealthcomplexmedical.com
You will receive a $250 credit to your out-of-pocket expenses when you use a designated facility.

Congenital heart disease services
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Congenital heart disease services are covered when ordered by a physician. These services must be received at a Congenital Heart Disease Resource Services program facility. Benefits are available for congenital heart disease services when the service meets the definition of a covered health service, and is not an experimental, investigational service, or an unproven service.
UnitedHealthcare notification is required before receiving all congenital heart disease services, including outpatient diagnostic testing, in utero services, and evaluation, including:
• Congenital heart disease surgical interventions
• Interventional cardiac catheterizations
• Fetal echocardiograms
• Approved fetal interventions
The services described in the “Transportation and lodging for bariatric services, transplants, transgender surgery, cancer, and CHD” section on page 34 are covered health services only in connection with CHD services received at a Congenital Heart Disease Resource Services program designated facility. You will receive a $250 credit to your out-of-pocket expenses when you use a designated facility.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

Contact UnitedHealthcare at the telephone number on your ID card for information about CHD services.

UnitedHealthcare notification
You must notify Custom Personal Health Support as soon as CHD is suspected or diagnosed.

Transportation and lodging for bariatric services, transplants, transgender surgery, cancer, and CHD
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. UnitedHealthcare will assist the patient and family with travel and lodging arrangements if the patient meets the criteria to receive services and resides more than 50 miles from a:

- Designated facility
- Qualified provider (as determined by UnitedHealthcare) for transgender services
- Congenital Heart Disease Resource Services facility for CHD services

With UnitedHealthcare, expenses for travel and lodging for the covered person and a companion are available under the UnitedHealthcare CDH Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to or from the designated facility (as listed above) for the purposes of an evaluation, an approved surgical procedure, or necessary postdischarge follow-up.
- Reasonable and necessary expenses, as determined by UnitedHealthcare, for lodging for the patient and one companion. Benefits are paid up to $50 for one person or up to $100 for two people.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to $100.

The lifetime maximum benefit is $10,000 per covered person for all transportation and lodging expenses incurred by the patient and companion(s) reimbursed under this Plan in connection with all bariatric, transplant, transgender, cancer, or CHD-related procedures combined.

Not covered:
- Transportation and lodging expenses not coordinated by UnitedHealthcare
- Expenses in excess of the stated reimbursement or benefit limits

Other covered services
- Abortions
- Allergy injections, testing, and serum, if performed in the physician’s office
- Anesthesia
- Blood and blood plasma transfusions and blood not donated or replaced
- Chemotherapy and radiation treatment
- Circumcision
- Cochlear implants
- Diabetic supplies and insulin
- Dialysis

For exceptions, refer to the “What is not covered” section that follows.

What is not covered
In addition to any other exclusions or limitations specified in this chapter, the Plan does not cover the following:

Alternative treatments
Including acupressure, aromatherapy, hypnotism, massage therapy, rolfing (except specifically covered under the UnitedHealthcare CDH Plan), or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Experimental, investigational, or unproven services
The fact that an experimental or investigational service or an unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition, as determined by UnitedHealthcare.
Experimental or investigational procedure
These include medical, surgical, diagnostic, mental health, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the utilization review organization or the claims administrator makes a determination regarding coverage in a particular case, are determined to be:

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

Unproven services
- Where reliable, authoritative evidence (as determined by UnitedHealthcare) does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis
- Where the conclusions determine that the treatment, service, or supply is not effective
- Where conclusions are not based on trials that meet either of the following designs:
  - Well-conducted, randomized controlled trials. Two or more treatments are compared with each other, and the patient is not allowed to choose which treatment is received.
  - Well-conducted cohort studies. Patients who receive study treatment are compared with a group of patients who received standard therapy. The comparison group must be nearly identical to the study treatment group.

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

Physical appearance
- Cosmetic procedures — cosmetic procedures are services that change or improve appearance without significantly improving the primary physiological function of the body part on which the procedure was performed, as determined by UnitedHealthcare
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, and flexibility
- Counseling for diversion or general motivation
- Treatment, services, or supplies for unwanted hair growth
- Wigs, regardless of the reason for the hair loss
- Removal of excess skin after weight loss (regardless of medical need)

Providers
- Unless under the direction of the physician, services performed by a provider with the following designations: CFA, CNA, CORT, CSA, CST, LCSA, LCST, LPN, LSA, LVN, OPA, RN, or SFA
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child, including any service the provider may perform on himself or herself
- Services performed by a provider with your same legal residence
- Charges made by a physician for or in connection with surgery that exceed the following maximum when two or more surgical procedures are performed at one time; the maximum amount payable will be the amount otherwise payable for the most expensive procedure and one half of the amount otherwise payable for all other surgical procedures

Services provided under another plan or program
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including but not limited to coverage required by Workers’ Compensation, no-fault auto insurance, or similar legislation
- If coverage under Workers’ Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness, or mental illness that would have been covered under Workers’ Compensation or similar legislation had that coverage been elected
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Charges payable under Medicare
- Charges that the participant is entitled to payment by a public program other than Medicaid
Travel

- Health services provided in a foreign country, unless required as emergency health services
- Travel, transportation, or living expenses, whether or not services are prescribed by a physician; some travel expenses related to covered transplantation services may be reimbursed at the claims administrator’s discretion

All other exclusions

- Accidents or injuries incurred while self-employed or employed by someone else for wages or profit, including farming
- Braces that straighten or change the shape of a body part, except as noted under durable medical equipment provisions
- Any charge for services, supplies, or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency
- Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing
- Charges for a stand-by provider or facility when no actual services have been performed
- Charges for or associated with patient advocacy
- Charges for services needed because the patient was engaged in an illegal activity when the injury occurred
- Charges or costs associated with sperm or ovum donations or the storage thereof
- Charges for the purchase or replacement of contact lenses; except the purchase of the first pair of contact lenses that follows cataract surgery will be covered
- Charges in excess of eligible expenses or in excess of any specified limitation
- Charges made for routine refractions, eye exercises, and surgical treatment for correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn
- Claims filed more than 12 months after the date of treatment or services
- Charges the provider is required to write off under another plan, when the other plan is the primary payer over the Wells Fargo plan
- Charges a network provider is required to write off
- Child care costs, including day care centers and individual child care
- Comfort or convenience items
- Educational services, except for nutritional counseling as noted under the “Nutritionists” section on page 28
- Foot care except when needed for severe systemic disease; this includes:
  - Hygienic and preventive maintenance foot care
  - Treatment of flat feet
  - Treatment of subluxation of the foot
  - Shoe orthotics (except as needed for foot amputees only)
- Growth hormone therapy
- Health services and supplies that do not meet the definition of a covered health service (see the “Covered health services” section on page 13 for more information)
- Health services for which you have no legal responsibility to pay or for which a charge would not ordinarily be made in the absence of coverage under the UnitedHealthcare CDH Plan
- Health services received after the date your coverage under the UnitedHealthcare CDH Plan ends, including health services for medical conditions arising before the date your coverage under the UnitedHealthcare CDH Plan ends
- Hippotherapy
- Interest or late fees due to untimely payment for services
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Surgical treatment of excessive sweating (hyperhidrosis) unless a predetermination by UnitedHealthcare determines the prescribed treatment is a covered benefit
- Pastoral counselors
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the UnitedHealthcare CDH Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
• Private duty nursing (see the “Extended skilled nursing care” section on page 25 for more information)
• Private room charges when facility has a semiprivate room available
• Prolotherapy
• Psychosurgery
• Respite care
• Rest cures
• Routine vision and hearing screening after age 17
• Reversal of voluntary sterilization and treatment of infertility after reversal of voluntary sterilization and any related charges
• Surgical treatment of obesity, excluding morbid obesity
• Treatment by artificial means for the purpose of causing a pregnancy, including but not limited to prescription drugs and assisted reproductive technology (ART) procedures, including but not limited to in vitro fertilization (IVF), gamete intracyclopreservation, or frozen embryo transfer
• Treatment of benign gynecomastia (abnormal breast enlargement in males)
• VNS therapy

Claims and appeals

If you use a network provider, the provider will obtain necessary pre-service authorizations and will file claims for you. However, you are responsible for following up to ensure the claim was filed within the proper time frame as noted below.

If you receive services from an out-of-network provider, it is your responsibility to make sure the claim is filed correctly and on time even if the out-of-network provider offers to assist you with the filing. This means that you need to determine whether your claim is an urgent care (including concurrent care claims), pre-service, or post-service claim. After you determine the type of claim, file the claim as noted below.

More specific information on filing claims can be found in the Benefits Book, “Appendix A: Claims and appeals.”

Urgent care claims (and concurrent care claims)

If the Plan requires pre-service approval in order to receive benefits for care or treatment and a faster decision is required to avoid seriously jeopardizing the life or health of the claimant, contact UnitedHealthcare at 1-800-842-9722.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the Plan requires pre-service approval in order to receive benefits under the Plan, contact UnitedHealthcare at 1-800-842-9722.

You may also file a written pre-service claim request at the following address:

UnitedHealthcare
PO Box 30884
Salt Lake City, UT 84130

Post-service claims

For services already received, a post-service claim must be filed with UnitedHealthcare within 12 months from the date of service, whether you file the claim or the provider files the claim.

If you receive services from an out-of-network provider, you are responsible for ensuring that the claim is filed correctly and on time, even if the out-of-network provider offers to file the claim on your behalf. The claim form is available at myuhc.com or by calling UHC Member Services at 1-800-842-9722. Late filing by an out-of-network provider is not a circumstance allowing for submission beyond the stated 12-month time frame.

You must complete the appropriate claim form and provide an itemized original bill* from your provider that includes the following:

• Patient name, date of birth, and diagnosis
• Date(s) of service
• Procedure code(s) and descriptions of service(s) rendered
• Charge for each service rendered
• Service provider’s name, address, and tax identification number

* Monthly statements or balance due bills are not acceptable. Photocopies are only acceptable if you’re covered by two plans and sent your primary payer the original bill.

Claims for separate family members should be submitted separately. If another insurance company pays your benefits first, submit a claim to that company first. After you receive your benefit payment, submit a claim to UnitedHealthcare and attach the other company’s Explanation of Benefits statements along with your claim. It is important to keep copies of all submissions.
Claims should be submitted to:
UnitedHealthcare
PO Box 30884
Salt Lake City, UT 84130

Complete information on filing claims can be found in the Benefits Book, “Appendix A: Claims and appeals.”

Claim questions, denied coverage, and appeals
If you have a question or concern about a benefit determination, you may contact Member Services before filing an appeal. For more information, see the “Contacts” section on page 1.

You may also file an appeal with UnitedHealthcare without first contacting Member Services. An appeal must be filed within 180 days of the date of the adverse determination of your initial claim, regardless of any verbal discussions that have occurred regarding your claim. Once you exhaust the internal appeals procedures, you are entitled to an external review of your claim.

Complete information on appeals is provided in the Benefits Book, “Appendix A: Claims and appeals.”

Right of recovery
The UnitedHealthcare CDH Plan has the right to recover benefits it has paid on your or your dependent’s behalf that were (a) made in error, (b) due to a mistake in fact, (c) paid before you meet the annual deductible, or (d) paid before you meet the coinsurance maximum for the UnitedHealthcare CDH calendar year. Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the UnitedHealthcare CDH Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the UnitedHealthcare CDH Plan will either:

• Require that the overpayment be returned when requested by UnitedHealthcare
• Reduce a future benefit payment for you or your dependent by the amount of the overpayment

If the UnitedHealthcare CDH Plan provides an advancement of benefits to you or your dependent (a) before you meet the annual deductible, or (b) meeting the coinsurance maximum for the UnitedHealthcare CDH Plan calendar year, the UnitedHealthcare CDH Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The UnitedHealthcare CDH Plan has the right to recover benefits it has advanced by:

• Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the UnitedHealthcare CDH Plan
• Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the UnitedHealthcare CDH Plan

Reimbursement
This method applies when you receive damages by settlement or verdict, or from an insurance company or otherwise, for an injury or other medical condition caused by a third party. The UnitedHealthcare CDH Plan will not cover the value of the services to treat such an injury or medical condition, or the treatment of such an injury or medical condition. The UnitedHealthcare CDH Plan may, however, advance payment to you for these medical expenses if you, or any person claiming through or on your behalf, agree to do both of the following:

• Grant to the UnitedHealthcare CDH Plan a first priority lien against any proceeds of any settlement, verdict, or insurance proceeds you receive as a result of the third party’s actions
• Assign to the UnitedHealthcare CDH Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the UnitedHealthcare CDH Plan’s claim for reimbursement

You must sign and deliver to the UnitedHealthcare CDH Plan any documents needed to protect the lien or to effect the assignment of your benefits. You must also agree not to take any action that is inconsistent with the UnitedHealthcare CDH Plan’s right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, or “made whole,” by the settlement, verdict, or insurance proceeds and regardless of whether costs are allocated to “medical expenses.” The UnitedHealthcare CDH Plan will not be responsible for bearing the cost of any legal fees you incur as a result of any action you take against the third party.

If you refuse to fully reimburse the UnitedHealthcare CDH Plan after receipt of a settlement, verdict, or insurance proceeds, the UnitedHealthcare CDH Plan will not pay for any future medical expenses, whether anticipated or unanticipated, relating to your injury or medical condition. In addition, the UnitedHealthcare CDH Plan may seek legal action against you to recover paid medical benefits related to your injury or medical condition.
Subrogation
Under the reimbursement method, you reimburse the UnitedHealthcare CDH Plan any money you receive through a settlement, verdict, or insurance proceeds. At its sole discretion, the UnitedHealthcare CDH Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the UnitedHealthcare CDH Plan is subrogated to all of your rights against any third party who is liable for your injury or medical condition, or for the payment for the medical treatment of your injury or medical condition, to the extent of the value of the medical benefits provided to you by the UnitedHealthcare CDH Plan. The UnitedHealthcare CDH Plan may assert this right independently of you.

You are obligated to cooperate with the UnitedHealthcare CDH Plan and its agents to protect the UnitedHealthcare CDH Plan’s subrogation rights. Cooperation means providing the UnitedHealthcare CDH Plan or its agents with any relevant information as requested, signing and delivering such documents as the UnitedHealthcare CDH Plan or its agents request to secure the UnitedHealthcare CDH Plan’s subrogation claim, and obtaining the UnitedHealthcare CDH Plan’s consent or its agent’s before releasing any third party from liability for payment of your medical expenses. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the UnitedHealthcare CDH Plan. Any costs incurred by the UnitedHealthcare CDH Plan in matters related to subrogation will be paid for by the UnitedHealthcare CDH Plan. The costs of legal representation you incur will be your responsibility.

Coordination of benefits

Coordination with other coverage
When you or your dependents have other group medical insurance (through your spouse’s or domestic partner’s employer, or Medicare, for example), the Wells Fargo health plan and the other plan may both pay a portion of covered expenses. One plan is primary, the other plan is secondary. This is called coordination of benefits. Please note the following:

- There is no coordination of benefits between Wells Fargo health plans; only one Wells Fargo health plan will provide coverage for eligible expenses.
- Wells Fargo health plans do not coordinate prescription drug benefits. For example, if you are covered under a Wells Fargo health plan and the other plan is primary, there is no secondary prescription drug benefit under the Wells Fargo health plan.

If the Wells Fargo health plan is secondary, it pays only the difference between the other plan’s benefit, if lower, and the normal Wells Fargo health plan benefit. When the primary plan pays a benefit that equals or exceeds the normal Wells Fargo health plan benefit, the Wells Fargo health plan pays nothing.

If you receive benefits from more than one group health plan (or a government-supported program other than Medicaid), the primary payer must process your claim before you can submit it to the secondary payer.

For detailed information regarding coordination of coverage, refer to the “Coordination with other coverage” section in “Chapter 1: An introduction to your benefits” of your Benefits Book.
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Chapter 3
Prescription drug benefit

The basics
Medco Health Solutions Inc. (Medco) administers the prescription drug benefits offered under the Plan. When you use medications from Medco’s Preferred Drug List (often referred to as a formulary) and use a pharmacy in the Medco network, you save money. The drugs on this list were chosen because they’ve been shown to work well in clinical trials and are cost effective.

Not all medications are covered by the Plan (even if other medications in the same therapeutic class are covered). To find out if your drug is covered by the Plan, or is subject to certain Plan provisions, visit medco.com or call Medco Member Services at 1-800-311-0835 to obtain information about the Plan’s prescription drug coverage.

Filling your prescription
You can have your prescriptions filled at any retail pharmacy, but you’ll save money if you use a pharmacy that participates in the Medco network. Most national and regional retail pharmacies do. When you have a prescription filled at a network pharmacy, you can take advantage of the discounted network rates and you’ll typically pay less than if you have a prescription filled at an out-of-network pharmacy.

And remember, you’ll save even more if you use Medco By Mail.

Retail pharmacies
You can get up to a 30-day supply of most prescriptions at a retail pharmacy. Exceptions include self-injectables, drugs that require special handling, and oral chemotherapy drugs. See the “Specialty care pharmacy” section on page 43 for more information.

Bring your ID card and pay your portion, as described in “Chapter 2: UnitedHealthcare Consumer Directed Health Plan” starting on page 5, for up to a 30-day supply of each prescription. Some drugs require prior authorization, so be sure to review the “Some prescriptions may require prior authorization” section on page 44 before filling a prescription for the first time.

If you use an out-of-network retail pharmacy, you’ll have to pay for your prescription up front and then submit a claim form with the original pharmacy receipt to Medco.

Medco will process your claim and coordinate payment with UnitedHealthcare to reimburse you, as shown in the “What you’ll pay for prescriptions” section on page 43, based on the Medco network contracted rate. If you use an out-of-network pharmacy, you are responsible for any difference between the out-of-network pharmacy’s price and Medco’s allowed amount.

To locate a Medco network pharmacy:
• Visit Medco’s website at medco.com, or you can link to Medco’s website through myuhc.com
• Call Medco at 1-800-311-0835
• Ask your retail pharmacy if it participates in the Medco network

Medco By Mail
Medco By Mail is a great choice for prescriptions that you take on a regular basis, such as cholesterol-lowering drugs or birth control pills. You can order up to a 90-day supply of your prescription through this service — just be sure to ask your doctor to write a prescription for a 90-day supply of each medication, plus refills up to one year, if appropriate. For example, ask your doctor to write a prescription for a 90-day supply with three refills, not a 30-day supply with 11 refills.

If a prescription is not available through Medco By Mail, it may be available from a retail pharmacy. Not all prescription drugs are covered, even if other drugs in the same therapeutic class are covered. To find out if your drug is on the Preferred Drug List, is covered by the Plan, or is subject to certain Plan provisions, go to medco.com or call Medco Member Services at 1-800-311-0835.

With Medco By Mail you get:
• Up to a 90-day supply of covered drugs for one copay
• Access to registered pharmacists 24 hours a day, 7 days a week
• Ability to refill orders online, by phone, or by mail — anytime day or night
• Free standard shipping
Ordering prescriptions
You can order new prescriptions or refill an existing prescription with Medco By Mail. When a new prescription is submitted, the order will be processed and shipped to you. Prescriptions are not held on file without being filled unless specifically requested. To refill a prescription, you'll need to reorder on or after the date indicated on the refill slip you received with your last shipment, or on the date listed on your prescription. The refill date will indicate the date when 70% of the drug will have been used. Most prescriptions are valid for one year from the date they are written, so ask your doctor to include up to three refills on your prescriptions if appropriate.

Three ways to order prescriptions:

• **Online.** Go to [medco.com](http://medco.com). If you are a first-time visitor, you’ll need to register using your ID number (shown on your ID card), and a recent retail or Medco By Mail prescription number. If you are already registered, simply sign on and click Order Prescriptions from the “Prescription and Benefits” tab.

• **By telephone or fax.**
  
  – For existing prescriptions:
    
    Call Medco Member Services at 1-800-311-0835 and use the automated phone service by following the prompts to request a Medco By Mail prescription refill. Have your ID number, your refill slip with the prescription number, and your credit card available.
  
  – For new prescriptions:
    
    Ask your doctor to call Medco at 1-888-327-9791 for faxing instructions.

• **By mail.** Send the refill and order forms (provided with your medication) along with your copay to:

  Medco Health Solutions of Fairfield  
  PO Box 747000  
  Cincinnati, OH 45274-7000

You’ll usually receive your prescription within eight days after your order is received. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when you order. If you don’t have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a participating retail pharmacy while your mail-order prescription is being processed.

Overnight or second-day delivery may be available in your area for an additional charge. Your mail-order prescription will include instructions for refills, if applicable. Your package will also include information about the purpose of the drug, correct dosages, and other important details.

Please note that dispensed drugs cannot be returned and federal law prohibits the return of controlled substances.

What’s covered

Covered prescriptions
In order for your prescription to be covered, it must meet Medco’s coverage criteria. All prescriptions are subject to the limitations, exclusions, and procedures described in this SPD. When more than one definition or provision applies, the most restrictive applies and exclusions take precedence over general benefit descriptions. The following prescription types are generally covered, but some may require prior approval, be limited in the amount you can get at any one time, or be limited by the age of the patient.

• Drugs that legally require a prescription, including compounded drugs where at least one ingredient requires a prescription, subject to the exceptions listed in this chapter

• Diabetic test strips, alcohol swabs, and lancets

• Insulin, insulin pens, insulin prefilled syringes, needles, and syringes for self-administered injections

The list of covered drugs, noncovered drugs, and coverage management programs and processes is subject to change. As new drugs become available, they will be considered for coverage under the Plan as they are introduced.

Drug categories
The Plan provides coverage for the following types of drugs:

• **Generic prescription drugs.** Your most affordable prescription option.

  The Food and Drug Administration (FDA) ensures that generic drugs meet the same standards for safety and effectiveness as their brand-name equivalents. The brand name is simply the trade name used by the pharmaceutical company to advertise the prescription drug. In the U.S., trademark laws do not allow a generic drug to look exactly like the brand-name drug. Although colors, flavors, and certain inactive ingredients may be different, generic drugs must contain the same active ingredients as the brand-name drug.

• **Preferred brand-name drugs.** Brand-name prescription drugs that are on the Preferred Drug List.

  These drugs may or may not have generic equivalents available.
• **Nonpreferred brand-name drugs.** Brand-name prescription drugs that are covered, but are not on the Preferred Drug List.

    Because effective and less costly generic or preferred brand-name drugs are available, you’ll pay more for these drugs. However, they are covered under the Plan.

**What you’ll pay for prescriptions**

With the UnitedHealthcare Consumer Directed Health Plan, if you have enough money in your HRA to cover the full cost of your covered prescription, you won’t have to pay anything out of pocket. Once your HRA dollars are spent, you’ll pay 20% of the full cost of your prescription at retail pharmacies, or 10% of the full cost of your prescription from Medco By Mail, after you’ve met your deductible.

*Note: Prescriptions filled at out-of-network pharmacies use Medco’s allowed amount to determine plan benefits and your cost share. You will pay the difference in cost between the cost of your out-of-network prescription cost and the Medco allowed amount. This difference is not eligible under your HRA and is not applied to your deductible and out-of-pocket maximum.*

You will need to pay for your prescription at the time of purchase and file a claim for reimbursement when:

- You do not have your ID card with you when you fill your prescription.
- You choose to use an out-of-network pharmacy.

The following Plan provisions also apply to all prescription drug claims processing:

- It’s standard practice in most pharmacies (and, in some states, a legal requirement) to substitute the generic equivalent for brand-name drugs whenever possible.
- Prescriptions for certain specialty drugs (typically self-injectables) cannot be filled at retail pharmacies. For more information, see the “Specialty care pharmacy” section on this page.
- Medco By Mail is the only approved mail-order provider. Any drugs ordered by mail from another provider will not be covered.
- Certain prescriptions have quantity limits. Talk to your pharmacist if you have questions about possible quantity limits for your prescriptions.
- You’ll need to get prior approval from Medco for certain prescriptions. For more information, see the “Some prescriptions may require prior authorization” section on page 44.

**Your ID card**

Shortly after you enroll in the Plan, you’ll receive an ID card from UnitedHealthcare. You’ll need to present your ID card each time you purchase prescription drugs at a network pharmacy. If you do not have your ID card with you, contact UnitedHealthcare Member Services at 1-800-842-9722 to get your UnitedHealthcare CDH Plan identification number. This information, along with the Wells Fargo group code (WELLSRX), will allow the pharmacist to process your prescription and determine the coinsurance amount. Alternatively, you can pay for your prescription up front and file a claim for reimbursement.

The information below is printed on your UnitedHealthcare CDH Plan ID card so the pharmacist can identify your prescription drug benefit under the Plan.

**Employer: Wells Fargo & Company Group Number:**

- 100241 (Gold)
- 101983 (Silver)
- 105909 (Gold Indemnity)
- 105910 (Silver Indemnity)

**RxBIN:** 610014

**RxGRP:** WELLSRX

**Specialty care pharmacy**

Complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis are treated with specialty drugs. These are typically drugs that are self-injectable or require special handling, or oral chemotherapy drugs. With this Plan, most specialty drugs are only covered when you use Medco’s specialty care pharmacy, the Accredo Health Group.

Contact the Accredo Health Group through Medco Member Services at 1-800-311-0835 to get:

- Up to a 90-day supply of your specialty drug for one copay amount.
- Expedited, scheduled delivery of your prescriptions at no extra charge.
- A care team that includes a clinical pharmacist who works closely with your physician to optimize your drug therapy regimens, ensure that each drug is being used appropriately, and make sure that you’re receiving consistent therapy. The care team will also monitor your product supply needs, answer your questions, assess clinical progress, and provide other personal support.
- Access to a pharmacist 24 hours a day, 7 days a week, for answers to your questions about specialty drugs.
- Coordination of home care and other health care services.
Some prescriptions may require prior authorization

With most of your prescriptions, no prior authorization is necessary. However, sometimes doctors write prescriptions that are “off label” (meaning, not for the purpose the drug is normally used for), or for an out-of-the-ordinary quantity, or there may be some other flag that triggers a need for a review.

When you receive a prescription, simply take it to your retail pharmacy or send it to Medco By Mail as described in this chapter. If prior authorization is necessary, your pharmacist or Medco will let you know. If it’s determined that prior authorization is necessary, you or your representative (e.g., your doctor or pharmacist) will need to call Medco at 1-800-753-2851 to initiate a coverage review.

If you use a retail pharmacy to fill your prescription, your doctor will need to give Medco information about your prescription. If you use Medco By Mail, Medco will contact your doctor directly to start the process. After the review is complete, Medco will send you and your doctor a letter confirming whether coverage has been approved (usually within two business days after Medco receives the information it needs).

If coverage is approved, you’ll pay your normal copay or coinsurance amount for your prescription. If coverage is not approved, you’ll need to pay for your medication in full, and the cost will not apply toward your deductible or out-of-pocket maximum for the Plan. Please note that prescriptions may fall under one or more coverage review programs. If coverage is denied, you have the right to appeal the decision. Information about the appeal process will be included in the notification letter you receive. The lists of drugs that require prior authorization are subject to change at any time as new prescription drugs, generic drugs, or additional information about existing drugs becomes available.

Below are some examples of drugs that may require prior authorization:

- Acne therapy (e.g., Solodyne®)
- Acthar® gel
- Anabolic steroids (e.g., Anadrol-50®, Winstrol®, Oxandrolone®)
- Anticonvulsant agents (e.g., Lyrica®)
- Antimalarial agents (e.g., Qualaquin®)
- Botulinum toxins (e.g., Botox® or Myobloc®)
- Cryopyrin-associated periodic syndrome (CAPS) agents (e.g., Arcalyst® [rilonacept] or Ilaris®)
- Dermatologic agents (e.g., Retin-A or Tazorac®)
- Erythoid stimulants (e.g., Epogen®, Procrit®, Aranesp®)
- Growth stimulating agents (e.g., Genetropin®, Norditropin®)
- Immune globulines (e.g., Vivaglobin®)
- Interferon agents (e.g., Intron® A, PegIntron™, or Pegasys®)
- Multiple sclerosis therapy (e.g., Avonex®, Betaseron®, or Copaxone®)
- Narcolepsy treatments (e.g., Provigil® or Nuvigil®)
- Neurological agents (e.g., Xenazine®, Xyrem®)
- Pain management (e.g., Lidoderm® patches)
- Phenylketonuria agents (e.g., Kuvan®)
- Paroxysmal Nocturnal Hemoglobinuria (PNH) agents (e.g., Soliris®)
- Severe plaque psoriasis drugs (e.g., Stelara®)
- Cancer treatments (e.g., Gleevec® or Avastin®)
- Weight loss drugs (e.g., Meridia®)

For some drugs, an automated process known as “smart prior authorization” is used to determine whether your prescription will be covered. Factors such as your medical history, drug history, age, and gender are used to determine whether a drug is covered. For example, rheumatoid arthritis therapies such as Enbrel®, Humira®, Kineret®, Remicade®, Orencia®, or Rituxan® are part of the smart prior authorization process.

Some drugs require what’s called “step therapy.” This means that a certain drug may not be covered unless you’ve first tried another drug or therapy. Examples include:

- **Allergy medications.** You may need to try generic fexofenadine before the Plan will cover other brand-name allergy medications such as Allegra D 24®, Clarinex®, Clarinex D®, Xyzal®.

- **Osteoporosis medications.** You may need to try alendronate (generic Fosamax®), Fosamax Plus D®, or Boniva® before the Plan will cover other brand-name osteoporosis medications such as Actonel®.

- **Pain medication.** You may need to try generic diclofenac or ibuprofen before the Plan will cover Celebrex®.

- **Proton pump inhibitors (PPIs).** You may need to try generic omeprazole (generic Prilosec®) or Nexium® before the Plan will cover other PPIs such as Aciphex®, Dexilant™, lansoprazole (generic for Prevacid®), pantoprazole (generic for Protonix®), Prevacid®, Prilosec®, Protonix®, or Zegrid®.


• Blood pressure medications. You may need to try generic Cozaar®, Hyzarr®, Diovan®, Diovan HCT®, Micardis®, or Micardis HCT® before the Plan will cover Atacand®, Atacand HCT®, Avapro®, Avalide®, Benicar®, Benicar HCT®, Teveten®, or Teveteen HCT®.

• Sleep aids. You may need to try generic zolpidem (generic Ambien®) before the Plan will cover other brand-name sleep aids such as Ambien CR®, Edluar®, Lunesta®, or Rozerem®.

• Migraine medications. You may need to try generic sumatriptan (generic Imitrex®) or Relpax® before the Plan will cover other brand-name migraine medications such as Amerge®, Axert®, Frova®, Maxalt®, Sumavel™, Treximet®, or Zomig®.

• Nasal steroids. You may need to try generic flutocasone propionate (generic Flonase®), generic flunisolide (generic Nasarel®), or Nasonex® before the Plan will cover other brand-name nasal steroid medications such as Beconase AQ®, Nasacort AQ®, Omnaris®, Rhinocort Aqua®, or Veramyst®.

For certain drugs, including the ones listed below, the Plan limits the quantity it'll cover. However, a coverage review by Medco By Mail may be available to request additional quantities.

• Antiviral agents (such as Valtrex®, Zovirax®)
• Antiemetic agents (such as Zofran®, Kytril®)
• Migraine therapies (such as Imitrex®, Imitrex®NS, Zomig®, Zomig-ZMT®)
• Oral bronchodilators (such as Albuterol®, Alupent®, Brethaire®, Maxaire®, Proventil®)
• Oral inhaled steroids (such as Advair®, Aerobid®, Azmacort®, Beclovent®, Flovent®, Pulmicort®, Qvar®, Vanceril®)
• Pain medications (such as Actiq®, Fentora®)
• Sleeping medications (such as zolpidem generic for Ambien®, Ambien CR®, Lunesta®, Rozerem®, Sonata®)

Please note that Medco By Mail does not automatically initiate a coverage review process for additional quantities. You or your doctor must initiate this process. Coverage review is not available for antifungal agents (e.g., Sproanox®, Lamisil®, or Diflucan®).

Prescriptions that are not covered

In addition to any other exclusions or limitations specified in this chapter, the Plan does not cover the following (even if prescribed by a physician):

• Compounded drugs that do not meet the definition of compounded drugs; medications of which at least one ingredient is a drug that requires a prescription

• Drugs or supplies that are not for your personal use or that of your covered dependent

• Drugs or supplies prescribed to treat any conditions specifically excluded by the Plan

• Drugs that are considered cosmetic agents or used solely for cosmetic purposes (e.g., anti-wrinkle drugs)

• Drugs that treat hair loss, thinning hair, unwanted hair growth, or hair removal

• Drugs that are already covered under any government programs, including Workers’ Compensation, or medication furnished by any other drug or medical service that you do not have to pay for

• Drugs that are not approved by the FDA, or that are not approved for the diagnosis for which they have been prescribed, unless otherwise approved by Medco based on clinical criteria as determined by Medco in its sole discretion

• Drugs that require administration by a dental professional (e.g., Arrestin, PerioChip)

• Investigational or experimental drugs, as determined by Medco in its discretion

• Drugs for which the intended use is illegal, unethical, imprudent, abusive, or otherwise improper

• Early refills, except in certain emergency situations (e.g., lost medication, traveling abroad). In these situations you may receive up to a 30-day supply at a retail pharmacy or a 90-day supply from Medco By Mail. If you are traveling abroad for more than 90 days, contact Medco Member Services at 1-800-311-0835. You’ll be responsible for any copays or coinsurance amounts.

• Infertility drugs

• Drugs you purchase outside the U.S. that you are planning to use in the U.S.

• Any drug used to enhance athletic performance

• Over-the-counter drugs or supplies, including vitamins and minerals (except as otherwise may be required by applicable federal law)

• Nutritional supplements, dietary supplements, meal replacements, infant formula, or formula food products

• Prescriptions requested or processed after your coverage ends; you must be an active participant in the Plan at the time your prescription is processed — not merely on the date your prescription is postmarked — for your prescription to be covered
• Prescriptions dispensed after one year from the original date of issue, more than six months after the date of issue for controlled substances, or if prohibited by applicable law or regulation
• Prescription drug claims received beyond the 12-month timely filing requirement; Medco must receive claims within 12 months of the prescription drug dispensed date
• Prescriptions that do not meet Medco’s coverage criteria
• Prescriptions exceeding a reasonable quantity as determined by Medco in its discretion
• Sexual dysfunction drugs
• Topical antifungal polishes (e.g., Penlac)
• Mail-order prescriptions that are not filled at Medco mail-order facilities

The following are not covered as prescription drug benefits under the Plan; however, they may be eligible for some level of coverage under the Plan. Please see “Chapter 2: UnitedHealthcare Consumer Directed Health Plan” starting on page 5 and contact UnitedHealthcare for more information.

• Allergy sera or allergens
• Contraceptive devices and inserts that require fitting or application in a doctor’s office, such as a diaphragm, Depo-Provera, or Norplant
• Injectable drugs that are not typically self-administered as determined by Medco in its discretion
• Immunization agents or vaccines (except Zostavax® administered at a pharmacy, or Vivivot Berna, which are covered through the prescription drug benefits of the Plan)
• Any drugs you are given at a doctor’s office, hospital, extended care facility, or similar institution
• Therapeutic devices, appliances, and durable medical equipment, except for glucose monitors

This list is subject to change. To determine if your prescription is covered, visit medco.com, sign on, and click My Rx Choices or Price a Medication; or contact Medco Member Services at 1-800-311-0835.

Out-of-pocket maximums

The amount that you pay for covered prescription drugs (retail pharmacy and Medco By Mail purchases) is applied to the Plan’s out-of-pocket maximum. See “Chapter 2: UnitedHealthcare Consumer Directed Health Plan” starting on page 5 for more information.

Prescription drug coordination of benefits

The prescription drug benefit under the Plan does not coordinate with other plans. The Plan provides primary payment only and does not issue detailed receipts for submission to other carriers for secondary coverage. If another insurance company, plan, or program pays your prescription benefit first, there will be no payments made under the Plan. Because the Plan does not have a coordination of benefits provision for prescription drugs, you may not submit claims to Medco for reimbursement after any other payer has paid primary or has made the initial payment for the covered drugs.

If you or a covered dependent is covered under this Plan and Medicaid or other similar state programs for prescription drugs, in most instances your prescription drug coverage under the Plan is your primary drug coverage. You should purchase your prescription drugs using your Medco ID card and submit out-of-pocket copay expenses to Medicaid or other similar state programs.

Claims and appeals

Filing a prescription drug claim

Urgent care claims

If the Plan requires preauthorization to receive benefits and a faster decision is required in order to avoid seriously jeopardizing the life or health of the claimant, contact Medco at 1-800-864-1135 or fax your request to 1-888-235-8551.

Important: Specifically state that your request is an urgent care claim.

Pre-service claims

If the Plan requires preauthorization in order to receive benefits, contact Medco at 1-800-753-2851, fax your pre-service claim request to 1-888-235-8551, or mail it to:

Medco Health Solutions
PO Box 14711
Lexington, KY 40512

Post-service claims

You will need to file a claim if you buy prescription drugs or other covered supplies from a pharmacy not in the Medco network or if your network pharmacy was unable to submit the claim successfully. All claims must be received by Medco within one year from the date the prescription drug or covered supplies were dispensed.

Your out-of-network claim will be processed faster if you follow the correct procedures. Complete the Prescription Drug Reimbursement form and send it with the original

UnitedHealthcare Consumer Directed Health Plan
prescription receipts. You may not use cash register receipts or container labels from prescription drugs purchased at an out-of-network pharmacy.

Prescription drug bills must provide the following information:

- Patient’s full name
- Prescription number and name of medication
- Charge and date for each item purchased
- Quantity of medication
- Doctor’s name

To get a Prescription Drug Reimbursement form:

- Go to medco.com, sign on, click Forms & cards, and download the claim form.
- Call Medco Member Services to request a form.

Send your claim to:

Medco Health Solutions Inc.
PO Box 14711
Lexington, KY 40512

You are responsible for any charges incurred but not covered by the Plan.

Please refer to “Appendix A: Claims and appeals” in your Benefits Book for more information regarding claims.

Medco claims questions, denied coverage, and appeals

If you have a question or concern about a claim already filed with Medco, you may contact Member Services before requesting an appeal.

You may also file an appeal to Medco without first contacting Medco Member Services. An appeal must be filed within 180 days from the date of the adverse determination of your initial claim regardless of any verbal discussions that have occurred regarding your claim. Once you exhaust the internal appeals procedures, you are entitled to an external review of your claim.

Complete information on appeals is provided in the Benefits Book, “Appendix A: Claims and appeals.”

Other things you should know

Drug safety

The risks associated with drug-to-drug interactions and drug allergies can be very serious. Whether you use Medco By Mail or a participating retail pharmacy, Medco checks for potential interactions and allergies. Medco also sends this information electronically to participating retail pharmacies.

Individuals who have a large number of prescription drugs may be restricted to the use of one retail pharmacy to ensure safety. High drug utilizers will be contacted by Medco to select one retail pharmacy to use to obtain all of their prescription drugs. If no pharmacy is selected, Medco will assign a pharmacy.

Medco may contact your doctor about your prescription

Medco can dispense a prescription only as it is written by a physician or other lawful prescriber (as applicable to Medco). Unless you or your doctor specifies otherwise, Medco dispenses your prescription with the generic equivalent when available and if permissible by law (as applicable to Medco).

You’re not limited to prescriptions on Medco’s Preferred Drug List, but you will probably pay less if you choose a drug from that list. If your doctor prescribes a drug that is not on the Preferred Drug List but there’s an alternative on the list, Medco may contact your doctor to see if that drug would work for you. However, your doctor always makes the final decision regarding your prescriptions. If your doctor agrees to use a preferred drug, you will never pay more than you would have for the original prescription, and will usually save money.

Prescription drug rebates

Medco administers the prescription drug benefit on behalf of Wells Fargo, but because the Plan is self-insured, all claims are paid by the company through our claims and prescription drug administrators.

Drug manufacturers offer rebates for certain brand-name medications on the Preferred Drug List. If you purchase a rebate-eligible drug at a network retail pharmacy or through Medco By Mail, a portion of the rebate is passed on to you automatically at the point of sale. The portion of the rebate passed on to you corresponds to your cost share of the drug. The portion passed on to Wells Fargo corresponds to the cost share of the drug paid for by Wells Fargo. Any rebates received by Wells Fargo are applied to the company’s cost of providing and administering health care benefits.

Genetic testing for prescription drugs

With certain prescription drugs, genetic testing can assist with determining the optimal dose for an individual. If you take one of these prescription drugs, you and your physician may be contacted to offer this testing. Participation in the testing is voluntary and any changes to your dosing or medication would be at the sole discretion of your physician.
Chapter 4
Mental health and substance abuse benefits

If you enroll in the UHC Consumer Directed Health Plan, you and your covered dependents have coverage for in-network and out-of-network mental health and substance abuse services as described in this chapter.

As always, it is between you and your provider to determine the treatments and procedures that best meet your needs. The terms of this chapter control what, if any, benefits are available under the UHC Consumer Directed Health Plan for the mental health and substance abuse services you receive. The fact that a provider has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular sickness or mental illness, does not mean that it is a covered health service as defined by the Plan. The definition of a covered mental health or substance abuse service under the Plan relates only to what is covered and may differ from what your provider deems to be a necessary health service.

United Behavioral Health

United Behavioral Health (UBH) is the claims administrator for mental health and substance abuse benefits described in this chapter, and provides confidential referrals for managed mental health and substance abuse care. The UBH network includes psychiatrists, psychologists, and master's level licensed therapists. The UBH Clinical Referral Line is staffed 24 hours a day, 365 days a year. For more information, see the “Contacts” section on page 1. To receive benefits through UBH, you must follow the process described in this chapter.
Your benefits and costs at a glance

The information in the following tables is subject to the limits and exclusions noted in this chapter. HRA, annual deductible, and annual out-of-pocket maximums apply.

Coverage for in-network or out-of-network mental health and substance abuse services is available. The annual deductible and annual coinsurance amounts found in “UnitedHealthcare CDH Plan: Your benefits and costs at a glance” chart on page 6 and “UnitedHealthcare CDH Plan, Indemnity Option: Your benefits and costs at a glance” chart on page 10 are integrated with medical, pharmacy, and mental health and substance abuse.

Please see the table below for more information.

<table>
<thead>
<tr>
<th>Plan features: MHSA in the CDH Plan</th>
<th>You pay (in network)</th>
<th>You pay (out of network)*</th>
<th>You pay (indemnity)**</th>
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<td>HRA pays 100%, then 40% of eligible covered expenses after deductible per visit or group visit</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible per visit or group visit</td>
</tr>
<tr>
<td>Inpatient</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 40% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 40% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
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<tr>
<td>Outpatient</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 40% of eligible covered expenses after deductible per visit or group visit</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible per visit or group visit</td>
</tr>
<tr>
<td>Structured outpatient</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 40% of eligible covered expenses after deductible</td>
<td>HRA pays 100%, then 20% of eligible covered expenses after deductible</td>
</tr>
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</tr>
</tbody>
</table>

* Benefits are determined using plans’ allowed amounts.

** Indemnity benefits determined using UBH allowed amounts.
Mental Health and Substance Abuse
Plan benefits
You can discuss your mental health or substance abuse needs in confidence or seek outpatient treatment referrals by calling either Employee Assistance Consulting (EAC) or UnitedHealthcare. When you call EAC or UnitedHealthcare and it’s not an emergency, they will give you the name, address, and telephone number of one or more network providers in your area so you can make an initial appointment.

For treatment to be a covered health service, UBH must determine that the treatment is medically necessary, based on the UBH coverage criteria guidelines.

Pre-service authorization required
The services listed below also require pre-service authorization in order to receive benefits under the Plan. For preauthorization, contact UHC at 1-800-842-9722. Any authorization is limited to a specific number of services for a specific period of time. If additional services are needed, you will need to obtain a new authorization before receiving those services. Refer to the “Pre-service claim” section in “Appendix A: Claims and appeals” in your Benefits Book for more information.

• Inpatient treatment
• Residential treatment centers (RTC)
• Partial hospitalization
• Intensive outpatient treatment
• Structured outpatient treatment
• Out-of-network substance abuse
• Autism treatment
• Psychological and neuropsychological testing

Emergency care
Please refer to the “Emergency care” section on page 24 for information.

Continuing review for hospitalization
While you are in the hospital, UBH will continue to review the medical necessity of your stay and treatment. If you receive services from an out-of-network therapist or facility, you have the option to move to a network therapist and facility where you will be covered at network benefits. If you choose not to transfer, you will receive the out-of-network benefit if available, or no coverage.

Residential treatment for children and adolescents
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for individuals who do not require acute inpatient care but who do need 24-hour medical supervision.

To be covered, the center must include an adequate educational program, as determined by UBH at its discretion, for school-aged children and adolescents.

Admission to a residential treatment center is not intended for use solely as a long-term solution or to maintain the stabilization acquired during treatment in a residential facility or program.

Psychological and neuropsychological testing
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. Psychological and neuropsychological testing is covered with UBH preauthorization, when conducted for the purpose of diagnosing a DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) mental disorder or in connection with treatment of such a mental disorder. Testing is not covered to diagnose or rule out:

• Attention Deficit Disorder (ADD)
• Attention Deficit/Hyperactivity Disorder (ADHD)
• Learning disorder or disability

Autism coverage
After the HRA is exhausted and you satisfy the deductible, you pay coinsurance. With United Behavioral Health preauthorization, the autism benefit provides coverage for Intensive Behavioral Therapies (IBT) for covered participants and dependents with autism and autism spectrum disorders.

Each case will be reviewed, diagnosis validated, and treatment plan evaluated for appropriateness. UBH level of care standards shall be applied.

The Plan covers IBTs, including applied behavioral analysis (ABA) and Repetitive Behavioral Intervention (RBI), with preauthorization.
What is not covered

In addition to any other exclusions and limitations specified in this chapter, the following are not covered as mental health or substance abuse benefits under the Plan. Some services may be eligible for some level of coverage under the Plan. Please see “Chapter 2: UnitedHealthcare Consumer Directed Health Plan” starting on page 5 and “Chapter 3: Prescription drug benefit” starting on page 41 for more information about services and prescription drugs that may be covered by the Plan.

- The Plan will not pay benefits for any other services, treatments, items, or supplies, other than IBT as defined by the Plan, even if recommended or prescribed by a physician, or if it is the only available treatment for autistic conditions.
- Behavioral health coverage for the autism benefit excludes tuition to publicly funded school-based programs for Pervasive Developmental Disorder (PDD) or any services provided by noneligible providers.
- Chelation therapy.
- Respite care.
- Vocational rehab.
- Educational services.
- Dolphin therapy.
- Recreational therapy.
- Academic education during residential treatment.
- Aversion therapy.
- Care that does not meet the UBH coverage criteria guidelines.
- Care that has not been preauthorized by UBH when required.
- Court-ordered psychiatric or substance abuse evaluation, treatment, or psychological testing — unless UBH determines that such services are medically necessary for the treatment of a DSM-IV mental disorder.
- Custodial care, regardless of the setting in which such services are provided. Custodial care is defined as services that do not require special skills or training, and that either:
  - Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring, and ambulating)
  - Do not require continued administration by trained medical personnel in order to be delivered safely and effectively
- Services for or related to educational testing or learning disabilities.
- Experimental or investigational therapies as determined by UBH. Generally, health care supplies, treatments, procedures, drug therapies, or devices that are determined to be any of the following:
  - Not generally accepted by informed health care professionals in the U.S. as effective in treating the condition, illness, or diagnosis for which their use is proposed
  - Not proven by scientific evidence to be effective in treating the condition, illness, or diagnosis for which their use is proposed
  - Undergoing scientific study to determine safety and efficacy
- Non-abstinence-based or nutritionally based substance abuse treatment.
- Charges for missed appointments, room or facility reservations, completion of claim forms, or record processing.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child, including any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence.
- Claims filed more than 12 months from the date of service.
- Services received after the date your coverage under the Plan ends, including services for conditions arising or under treatment before your coverage ends.
- Interest or late fees charged due to untimely payment for services.
- Private duty nursing (see the “Extended skilled nursing care” section on page 25 for more information).
- Psychiatric or psychological examinations, testing, or treatment that UBH determines is not medically necessary, but which nevertheless may be required for purposes of obtaining or maintaining employment or insurance, or pursuant to judicial or administrative proceedings.
- State hospital treatment, except when determined by UBH to be medically necessary.
- Therapies that do not meet national standards for mental health professional practice: for example, primal therapy, bioenergetic therapy, crystal healing therapy, rolfing, megavitamin therapy, or vision perception training.
• Treatment for personal or professional growth, development, or training, or professional certification.
• Treatment for stammering or stuttering, including that to maintain employment or insurance.
• Treatment not provided by an independently licensed psychiatrist, psychologist, or master-level mental health provider.
• Treatment of chronic pain, except when rendered in connection with treatment of a DSM-IV mental disorder.
• Charges above reasonable and customary amounts as calculated by UBH using data tables from the Health Insurance Association of America.
• Services that do not meet the criteria established in, or are excluded under, the claims administrator’s medical coverage policy guidelines.

Claims and appeals
All claims must be filed within 12 months from the date of service.

If you use a network provider, the provider will file the claim for you, and UBH will pay the provider directly.

If you use an out-of-network provider to file your claim, complete an UHC or UBH claim form, attach itemized bills, and send to:

UnitedHealthcare
PO Box 30884
Salt Lake City, UT 84130

You can request or print a claim form by:
• Calling UHC at 1-800-842-9722 to request a form
• Going to liveandworkwell.com (access code: wells Fargo) or by going to myuhc.com

If the provider files a claim on your behalf, you are still responsible for ensuring it is filed properly and within the required time frame. More information on filing claims can be found in the Benefits Book, “Appendix A: Claims and appeals.”

Mental health and substance abuse claim questions, denied coverage, and appeals
If you have questions or concerns about a claim already filed with UBH, you may contact Member Services before filing an appeal with UBH. For more information, see the “Contacts” section on page 1.

You may also file a written appeal with UBH without first contacting UBH Member Services. An appeal must be filed within 180 days of the date of the adverse determination of your initial claim regardless of any verbal discussions that have occurred regarding your claim. Once you exhaust the internal appeals procedures, you are entitled to an external review of your claim.

Complete information on appeals is provided in the Benefits Book, “Appendix A: Claims and appeals.”