Summary Plan Description

UnitedHealthcare PPO Plan
Effective January 1, 2011
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# Contacts

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<tr>
<th>Information about the UnitedHealthcare PPO Plan</th>
<th>1-800-842-9722</th>
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<tbody>
<tr>
<td>• Medical claims information</td>
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<td>• Authorization of medical services</td>
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<td>• Optum Connect24 NurseLine</td>
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**Health information**

<table>
<thead>
<tr>
<th>Information about mental health and substance abuse</th>
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<tbody>
<tr>
<td></td>
<td>1-800-842-9722</td>
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<tr>
<td></td>
<td><a href="http://liveandworkwell.com">liveandworkwell.com</a> (access code: wells Fargo)</td>
</tr>
<tr>
<td></td>
<td><a href="http://myuhc.com">myuhc.com</a></td>
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<td></td>
<td>Employee Assistance Consulting</td>
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<tr>
<td></td>
<td>1-888-327-0027</td>
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<tr>
<td></td>
<td>For TDD access for persons with hearing impairments, please call 1-877-411-0826.</td>
</tr>
<tr>
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<td><a href="http://eac.portal.wellsfargo.com">eac.portal.wellsfargo.com</a></td>
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<tr>
<th>Information about Medco prescription drugs and Medco Health Solutions</th>
<th>Medco Health Solutions</th>
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<tr>
<td></td>
<td>1-800-309-5507</td>
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<td><a href="http://medco.com">medco.com</a></td>
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<th>Information about enrollment</th>
<th>Teamworks</th>
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<td></td>
<td>HR Service Center</td>
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<td></td>
<td>1-877-HRWELLS (1-877-479-3557)</td>
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<tr>
<td></td>
<td>For TDD access for persons with hearing impairments, please call 1-800-988-0161.</td>
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<td></td>
<td><a href="mailto:hrsc@wellsfargo.com">hrsc@wellsfargo.com</a></td>
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<tr>
<th>Information about premiums for the UnitedHealthcare PPO Plan</th>
<th>Check your enrollment materials, or go to Teamworks.</th>
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<tr>
<th>Information about providers</th>
<th>Provider Directory Service</th>
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<tr>
<td></td>
<td>geoaccess.com/directoriesonline/wf</td>
</tr>
<tr>
<td></td>
<td>Medical Plan Comparison Tool</td>
</tr>
<tr>
<td></td>
<td><a href="http://wf.chooser.pbgih.org">wf.chooser.pbgih.org</a></td>
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Chapter 1
Administrative information

The basics
This Summary Plan Description (SPD) covers the provisions of the UnitedHealthcare PPO 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 the treatment and care you receive.

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. UnitedHealthcare 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.
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 Inc.**
  
  PO Box 14711  
  Lexington, KY 40512

  1-800-309-5507
Chapter 2
UnitedHealthcare PPO Plan

The basics
The UnitedHealthcare PPO Plan (the Plan) coverage option under the Wells Fargo & Company Health Plan is a managed-care option that is available nationwide, except in the state of Hawaii. Your benefits depend on whether you live within the Choice Plus network area or outside of it and where you choose to receive care. The state in which you reside determines the premium you pay. Several cost groups are related to the cost of care in each state. For example, if medical services are relatively expensive in your state of residence, you may be enrolled in a higher cost group and your premium will be higher, whereas the premium will be lower in states where medical services are relatively less expensive. Refer to the Rates and Comparison Charts on Teamworks for the cost of your plan. Also, you can pay less for medical services by using the Choice Plus network of doctors and hospitals associated with the Plan, or you can choose out-of-network services at a higher cost.

The Plan is a self-insured plan. That means benefits are paid from company and team member contributions. Wells Fargo contracts with UnitedHealthcare to perform administrative services and process claims, which in turn contracts with hospitals and doctors to create the Choice Plus network, covering most of the U.S. For purposes of this Plan coverage option, UnitedHealthcare is the claims administrator.

When you are enrolled in this Plan, you agree to give your health care providers authorization to provide the claims administrator access to required information about the care provided to you. The claims administrator may require this information to process claims and to conduct utilization review and quality-improvement activities and for other health plan activities, as permitted by law. The claims administrator may release the information if you authorize it 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.

How the Plan works
Choice Plus network
If you live in a Choice Plus network area and enroll in the Plan, you can choose where to receive care each time you visit a doctor or hospital — either within the Choice Plus network or outside the network.

Network benefits
To receive network benefits, it is recommended that your care be coordinated by your primary care physician (PCP). Your PCP provides most of your care and refers you to network specialists. If your PCP admits you for inpatient care at a network hospital, your PCP will obtain the necessary authorization. If you use a network hospital for inpatient services without authorization, out-of-network benefits apply. (See the “Using the Choice Plus network” section on page 12 and the “Custom Personal Health Support” section on page 12.)

Using the network can save you money. When your care is provided by a network provider and you receive covered health services, you:
• Pay 100% of expenses until you reach a $300 annual deductible per person ($600 per family).
• Pay 20% for most covered health services, after meeting the deductible.
• Pay nothing for eligible preventive care — the Plan pays 100%.
• Have an annual out-of-pocket maximum of $2,300 per person ($4,600 per family). The deductible applies to your out-of-pocket maximum.
• Must contact UnitedHealthcare for hospitalization and some surgical procedures before receiving services.

To identify providers who participate in the Choice Plus network, access the Provider Directory Service through Teamworks or at geoaccess.com/directoriesonline/wf, or you may also identify network 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.
Out-of-network benefits

Unless it’s an emergency, when you use out-of-network providers, you:

- Pay 100% of expenses until you reach a $400 annual deductible per person ($800 per family).
- Pay 40% of eligible expenses for most covered health services, after meeting the deductible.
- Pay 40% of the eligible expenses for eligible preventive care expenses; the deductible does not apply to preventive care.
- Pay 100% of expenses over the eligible expenses.
- Pay 100% of expenses that are not for a covered health service.
- Submit claim forms for all expenses.
- Have an annual out-of-pocket maximum of $4,400 per person ($8,800 per family) The deductible applies to your out-of-pocket maximum.
- Must contact UnitedHealthcare for hospitalization and some surgical procedures before receiving services. (See the “Custom Personal Health Support” section on page 12 for notification procedures.)

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.

Indemnity Plan

If you live outside the Choice Plus network area and enroll in the Plan, you will receive coverage through the Indemnity feature of this Plan. Indemnity benefits are determined using UHC’s allowed amounts. You may choose any doctor or hospital.

In general, you:

- Pay 100% of expenses until you reach a $300 annual deductible per person ($600 per family).
- Pay 20% for most covered health services, after meeting the deductible.
- Pay nothing for eligible preventive care; the deductible does not apply to eligible preventive care.
- Pay 100% of expenses over the eligible expense.
- Pay 100% of expenses not considered a covered health service.
- Submit claim forms for all expenses for Indemnity services.
- Have an annual out-of-pocket maximum of $2,300 per person ($4,600 per family) The deductible applies to the out-of-pocket maximum.
- Must contact UnitedHealthcare for hospitalization and some surgical procedures before receiving services.
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>Benefit features</th>
<th>Network benefits</th>
<th>Out-of-network benefits*</th>
<th>Indemnity benefits**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong>&lt;br&gt;(expenses paid toward the annual deductible include medical and mental health and substance abuse; prescription drugs do not apply towards the annual deductible)&lt;br&gt;&lt;br&gt;Must use network physician; can self-refer to OB/GYN.</td>
<td>Individual $300; family $600</td>
<td>Individual $400; family $800</td>
<td>Individual $300; family $600</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum&lt;br&gt;(includes the deductible; expenses paid toward the annual out-of-pocket maximum include medical and mental health and substance abuse; prescription drugs do not apply towards the annual out-of-pocket maximum)&lt;br&gt;</td>
<td>Individual $2300; family $4600</td>
<td>Individual $4400; family $8800</td>
<td>Individual $2300; family $4600</td>
</tr>
<tr>
<td>Primary care physician (PCP) requirements</td>
<td>Must use network physician; can self-refer to OB/GYN.</td>
<td>You may use any physician.</td>
<td>You may use any physician.</td>
</tr>
<tr>
<td>Doctor’s office visits&lt;br&gt;Maximum visits apply to some service categories; see benefits descriptions for details.&lt;br&gt;</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Preventive care&lt;br&gt;Annual physicals, routine well-baby visits, routine immunizations</td>
<td>Plan pays 100% for eligible preventive care services, based on annual exam schedule.</td>
<td>You pay 40%; no deductible.</td>
<td>Plan pays 100% for eligible preventive care services, based on annual exam schedule.</td>
</tr>
<tr>
<td>Urgent care clinics</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Durable medical equipment and prosthetics</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Emergency room&lt;br&gt;For emergency care as defined by the Plan</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Maternity</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
</tbody>
</table>

* Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
** Indemnity benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
<table>
<thead>
<tr>
<th>Benefit features</th>
<th>Network benefits</th>
<th>Out-of-network benefits*</th>
<th>Indemnity benefits**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>You pay 20% of</td>
<td>You pay 40% of eligible</td>
<td>You pay 20% of eligible</td>
</tr>
<tr>
<td>(Limit of 100 visits in a calendar year (network and out-of-network combined))</td>
<td>eligible covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
</tr>
<tr>
<td>Hospice care</td>
<td>You pay 20% of</td>
<td>You pay 40% of eligible</td>
<td>You pay 20% of eligible</td>
</tr>
<tr>
<td>(This is if you reside outside the UHC network)</td>
<td>eligible covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
</tr>
<tr>
<td>Hospital care</td>
<td>You pay 20% of</td>
<td>You pay 40% of eligible</td>
<td>You pay 20% of eligible</td>
</tr>
<tr>
<td>(Inpatient hospital stay or other care rendered in a hospital setting)</td>
<td>eligible covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
</tr>
<tr>
<td>Outpatient surgery and diagnostic and therapeutic services (includes labs and x-rays)</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>See the “What you’ll pay for prescriptions” table on page 40 for coverage information.</td>
<td></td>
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<tr>
<td>Therapy and chiropractic services</td>
<td>You pay 20% of</td>
<td>You pay 40% of eligible</td>
<td>You pay 20% of eligible</td>
</tr>
<tr>
<td>(Occupational, speech, and physical therapy; 90 visits per calendar year all combined (network and out-of-network combined))</td>
<td>eligible covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
</tr>
<tr>
<td>Chiropractic care; 26 visits per calendar year max (network and out-of-network combined)</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>You pay 20% of</td>
<td>You pay 40% of eligible</td>
<td>You pay 20% of eligible</td>
</tr>
<tr>
<td>(Maximum of 26 visits per year (network and out-of-network combined))</td>
<td>eligible covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
<td>covered expenses after the deductible.</td>
</tr>
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* Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.

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<table>
<thead>
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<th>Indemnity benefits**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled nursing facility</strong></td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>Limited to 100 days per calendar year, network and out-of-network combined</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision and hearing</strong></td>
<td><em>Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.</em></td>
<td><strong>Indemnity benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.</strong></td>
<td></td>
</tr>
<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>
<td>Only covered as part of eligible preventive well child care.</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>Not covered.</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
</tr>
<tr>
<td>(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>
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</tr>
<tr>
<td><strong>Family planning</strong> (infertility treatment subject to a $10,000 lifetime maximum)</td>
<td>You pay 20% of eligible covered expenses after the deductible.</td>
<td>You pay 40% of eligible covered expenses after the deductible.</td>
<td>You pay 20% 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 (limited to the lifetime maximum benefit noted above, network and out-of-network combined)</td>
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<tr>
<td><strong>Mental health and substance abuse</strong></td>
<td>See “Chapter 4: Mental health and substance abuse benefits” starting on page 47 for plan information.</td>
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</tbody>
</table>

* Out-of-network benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.

** Indemnity benefits determined using UHC’s, Medco’s, or UBH’s allowed amounts.
<table>
<thead>
<tr>
<th>Highlights</th>
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<td><strong>Online Health Assessment</strong></td>
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<td><strong>Maternity Support Program</strong></td>
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<td><strong>Healthy resources</strong></td>
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<tr>
<td><strong>Health improvement programs</strong></td>
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</table>

**Member Services and website**

1-800-842-9722
myuhc.com

**Nurse line for members**

Registered nurses are available 24 hours a day, 365 days a year, to deliver symptom support, evidence-based health information and education, and medical information. Optum Connect24 NurseLine: 1-800-842-9722 and choose “Speak with a Nurse.”

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**Coverage while traveling outside the United States**

Coverage is available for emergency treatment and urgent care covered health services needed when traveling outside the U.S. if UnitedHealthcare is notified upon your return to the U.S. and before the claim is filed. If you do not notify UnitedHealthcare upon your return, out-of-network benefits will apply.

**Covered health services**

Covered health services include services and supplies provided for the purpose of preventing, diagnosing, or treating a sickness, injury, mental illness, substance abuse or their symptoms. See the “What the Plan covers” section on page 16 and the “What is not covered” section on page 30 for additional information. Experimental or investigational services and unproven services are not a covered health service. (See the “Experimental, investigational, or unproven services” and the “Unproven services” sections on page 30 for more details). UnitedHealthcare has the discretion to determine what a medically necessary covered health service is based on Plan terms and established UnitedHealthcare medical policies. 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 all of the following are true:

- When the Plan is in effect
- When the person who receives services is enrolled and meets all eligibility requirements specified in the Plan

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

**Eligible expenses**

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

Eligible expenses (the “allowed amount”) 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 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.

Eligible expenses are determined solely in accordance with the claim administrator’s reimbursement policy guidelines. The reimbursement policy and guidelines are developed at the claim administrator’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies chosen by the claims administrator:

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

**Annual deductible**

The annual deductible is the out-of-pocket expense you pay each calendar year before benefits are paid. (For deductible amounts, see the “Your benefits and costs at a glance” chart on page 7.)

Family members’ deductible expenses can be combined to meet the family deductible. The Plan does not require that each covered family member meets the individual deductible.

After your deductible is met, the Plan begins paying benefits. You do not have to pay a deductible for medical services when you receive eligible preventive care benefits. (See the “What the Plan covers” section on page 16.)

The following expenses do not count toward satisfying your deductible:

- Expenses not covered by the Plan
- Expenses above the eligible expenses cost
- Expenses not considered a covered health service
- Prescription drug coinsurance or the copay for mail-order prescriptions
- Any amount that you must pay due to a reduction in benefits because you did not conform to UnitedHealthcare guidelines

**Out-of-pocket maximum expense**

After your out-of-pocket expenses reach a certain dollar limit — the individual, out-of-pocket maximum — the Plan pays 100% of most remaining covered expenses for the rest of the calendar year. (For out-of-pocket maximum amounts, see the “Your benefits and costs at a glance” chart on page 7.)

If enrolled family members’ combined expenses meet the family out-of-pocket maximum, the Plan pays 100% of most eligible expenses for other enrolled family members for the rest of the year. If you use a combination of network, out-of-network, or Indemnity coverage within the Plan during the same calendar year, your eligible out-of-pocket expenses during the year count toward both maximums.
The following expenses do not count toward your out-of-pocket maximum and are not payable by the Plan even after meeting your annual out-of-pocket maximum:

- Expenses not covered by the Plan or exceeding Plan limits
- Expenses over the eligible expense
- Expenses not considered a covered health service
- Prescription drug copay or coinsurance
- Any amount you must pay due to a reduction in benefits because you did not notify UnitedHealthcare

**Using the Choice Plus network**

If you use a Choice Plus network provider, it is suggested, but not necessary, to have your PCP refer you to a network specialist for network benefits. Your network primary care physician is the key to network benefits. When you visit your PCP or authorized Choice Plus network specialist, present your UnitedHealthcare identification card.

**Specialists**

If you see a specialist who is part of the Choice Plus network, no referral is necessary, and you will receive network benefits.

If you are referred to an out-of-network specialist, you must receive an authorized referral from your PCP and UnitedHealthcare. After receiving authorization, the first visit is covered at the network benefit level. Before receiving additional services, you are again responsible for obtaining the necessary authorizations from UnitedHealthcare for those services to be eligible for network benefits. If your PCP gives you a referral but you do not receive a written authorization from UnitedHealthcare, services will be covered at the out-of-network level.

You always have the option of visiting a specialist that is not a network provider. If you do, out-of-network benefits apply.

**OB/GYN providers**

Women may visit a network obstetrician/gynecologist (OB/GYN), without authorization from a PCP, for OB/GYN-related and maternity care issues only. You may not use an OB/GYN for routine physicals or non-OB/GYN services.

If you see an out-of-network OB/GYN, out-of-network benefits apply.

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**Custom Personal Health Support**

**The basics**

The Custom Personal Health Support program is designed to encourage an efficient system of care by identifying and addressing possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. The Custom Personal Health Support activities are not a substitute for the medical judgment of your physician. The ultimate decision as to what medical care you actually receive must be made by you and your physician.

**Who must contact UnitedHealthcare**

If you receive services from your PCP, your PCP will manage the UnitedHealthcare notification process for you. If you do not receive services from your PCP, or you use out-of-network providers or Indemnity providers, you are responsible for completing the UnitedHealthcare notification process and receiving necessary authorization before receiving services, even if your PCP has referred you to the out-of-network provider.

Covered health services under this Plan are subject to UnitedHealthcare notification. To the extent that UnitedHealthcare notification applies, no benefits are payable unless UnitedHealthcare determines that the medical expenses are covered under the Plan.

**When to notify UnitedHealthcare**

The services that require you to notify UnitedHealthcare include:

- Bariatric
- Cancer resource services
- Cardiac imaging or stress tests
- Cardiac rehabilitation services
- Congenital heart disease services
- CT or CAT
- Dental services related to an accident
- Durable medical equipment (more than $1,000, either purchase price or cumulative rental of a single item)
- Heart catheterization
- Home health care services
- Home IV infusion
- Hospice care
- Inpatient facility admissions
- Maternity (birthing care services)
- Maternity services (if stay exceeds the 48- or 96-hour guidelines)
- MRI scans
- Outpatient therapeutic
- Outpatient treatments
- Prosthetic devices (more than $1,000)
- Reconstructive procedures
- Skilled nursing services
- Temporomandibular joint disorder (TMJ), preauthorization required
- Transgender services
- Transplant services

For inpatient treatment, you must notify UnitedHealthcare of the scheduled admission date at least five working days before the start of the treatment. If an admission date is not set when the treatment is planned, you must call UnitedHealthcare again as soon as the admission date is set.

UnitedHealthcare may be contacted by calling the Member Services number listed on your ID card. Approval by UnitedHealthcare does not guarantee that benefits are payable under the Plan. UnitedHealthcare only determines that a service is appropriate for a certain condition, based on UnitedHealthcare guidelines; it does not guarantee in-network benefits. Actual benefits are determined when the claim is filed and are based on:

- The services and supplies actually performed or given
- Whether the provider is a network or out-of-network provider
- Whether the service is a covered health service
- Your eligibility under the Plan on the date the services and supplies are performed or given
- Deductibles, coinsurance, maximum limits, and all other terms of the Plan

Custom Personal Health Support is not a substitute for the medical judgment of your physician. The decision as to what medical care you receive must be made by you and your physician. The terms of the Plan determine if benefits are available for those services.

**How Custom Personal Health Support works**

UnitedHealthcare Custom Personal Health Support is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to Custom Personal Health Support activities and is an opportunity for you to let UnitedHealthcare know that you are planning to receive specific health care services.

**How to notify UnitedHealthcare**

Except in emergencies, UnitedHealthcare must be contacted before your hospitalization or treatment. (For additional information, see the “In an emergency” section on page 14.)

**Network coverage**

If you use your PCP or a network specialist to whom you are referred, your PCP or network specialist will manage the UnitedHealthcare process for you.

For hospitalization services, hospitalization must be:

- Authorized in advance by your PCP or network specialist and UnitedHealthcare
- Provided in a network hospital

In rare circumstances where a network provider is not available or cannot provide necessary services or treatment, you may be able to receive network coverage from an out-of-network provider. To receive this coverage, UnitedHealthcare and your PCP must first authorize an initial visit to the out-of-network provider. If after the initial visit, the out-of-network provider indicates that additional services are required, you must:

- Get authorization from your PCP and UnitedHealthcare for the additional services
- In the case of hospitalization, you must notify UnitedHealthcare

**Out-of-network or Indemnity coverage**

You are responsible for contacting UnitedHealthcare if you:

- Use an out-of-network provider
- Are covered under the Indemnity portion of the Plan

Call UnitedHealthcare as soon as your doctor recommends surgery or hospitalization to begin the UnitedHealthcare notification process. Allow from three to five days for the UnitedHealthcare notification process. When it is complete, UnitedHealthcare will:

- Call you to discuss the decision
- Send you, your doctor, and the hospital a letter confirming the decision
If UnitedHealthcare does not approve the request, the letter will include a specific explanation. If you find you do not agree with the explanation, you have the option to appeal the decision. See the “Claims and appeals” section on page 33.

Instructions for the appeal procedure will be included in the letter.

**Inpatient care advocacy**

If you become hospitalized, a UnitedHealthcare nurse will work with the facility and your doctor to make sure that you are getting the care you need and that your doctor’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.

**Disease management**

Members with certain diseases are invited to participate in disease management programs to help them understand how to better manage their care. Disease management programs are available for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, and lower-back pain. Contact Custom Personal Health Support for more information.

**Exceptions to the UnitedHealthcare notification process**

**Urgent care**

After you satisfy the deductible, you pay coinsurance. If you are in the Choice Plus network area and you require nonemergency care when your PCP is not available, you may be able to access one of UnitedHealthcare’s urgent care facilities if there’s one in your area. You don’t need to notify UnitedHealthcare when you visit these facilities. Check with UnitedHealthcare customer service to see if there is a network urgent care facility in your area.

**In an emergency**

In a true medical emergency, you may go to any hospital for treatment. To confirm coverage, show your UnitedHealthcare ID card. The hospital can contact UnitedHealthcare at the number on the card. For inpatient admissions, you are responsible for ensuring that UnitedHealthcare is notified of your hospital admission within two business days, if reasonably possible.

The Plan provides benefits for emergency health services when required for stabilization as provided by or under the direction of a physician.

**Network coverage**

Network benefits are paid for emergency services, as defined by the Plan, even if provided by an out-of-network provider.

If you are confined in an out-of-network hospital after you receive emergency services, UnitedHealthcare must be notified within two business days, if reasonably possible. UnitedHealthcare may elect to transfer you to a network hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-network hospital after the date UnitedHealthcare decides that a transfer is medically appropriate, out-of-network benefits may be available if the continued stay is determined to be a covered health service.

If you are admitted as an inpatient to a network hospital within 24 hours of receiving treatment for the same condition as an emergency service, you will not have to pay the coinsurance for emergency services. The coinsurance for an inpatient stay in a network hospital will apply instead.

**Nonemergency care away from home**

When you’re traveling outside the network area and you have a medical problem, sometimes the “true emergency” criteria are not met but you can’t wait for care until you get home. You may call customer service or access myuhc.com to locate a network provider away from home.

**Myuhc.com**

As a Plan participant, myuhc.com is your website that helps you to take charge of your health care. It’s quick, secure, and simple to use. The site provides you with instant, real-time access to tools and information so you can get the answers you need when, where, and how you want them.

Here are some of the things you can do on myuhc.com:

- Verify eligibility and deductible.
- View your benefits.
- Confirm that a claim has been paid or has been received and is being processed.
• Print a temporary ID card or order a replacement ID card.
• Search for in-network primary care physicians, specialists, and hospitals.
• Compare hospitals based on procedures and criteria of interest to you.
• Visit Optum Live and chat online with a registered nurse.
• View and print your Explanation of Benefits instead of receiving mail at home.
• Update your Coordination of Benefits information.
• Obtain in-depth information on hundreds of health topics, procedures, and conditions through Healthwise and Best Treatments.

Optum Connect24 NurseLine health information service

Optum Connect24 NurseLine is a confidential health information service offered to all Plan participants. When you're faced with a medical decision and want more information, you can speak with a specially trained nurse. You can either call Optum Connect24 NurseLine through UnitedHealthcare Customer Service or access the service at myuhc.com. Optum Connect24 NurseLine helps you get information about:
• Test and treatment safety
• The risks and benefits of a particular medical procedure
• Alternatives to hospitalization
• Medication side effects
• Ways to prevent or manage chronic illness
• Pregnancy-related concerns
• Lifestyle changes such as smoking cessation, weight loss, exercise, and high blood pressure or cholesterol control
• Home treatment of minor injuries and illnesses

The nurses won’t tell you what to do, but they can give you information about alternatives, help you understand the issues before you decide, and provide support. You and your health care provider have ultimate responsibility for determining appropriate treatment and care.

Note: Calling Optum Connect24 NurseLine instead of your PCP or UnitedHealthcare does not qualify as authorization of medical services under the Plan.

You may also get information on medical topics by listening to audio tapes. You can access Optum Connect24 NurseLine’s health information library and select from 1,100 topics.

Optum Connect24 NurseLine also offers live chat with registered nurses by going to myuhc.com. This online service is available 24 hours a day. During your chat, the nurse can display web pages and suggest other helpful resources related to the topic you are discussing. At the end of the session, you can request a transcript of the conversation and displayed web pages for future reference. Note that nurses participating in your live chat session cannot address urgent symptoms.

It's easy to access live Nurse Chat:
2. Click the Nurse Chat link.
3. Provide a screen name for the nurse to use during your chat.
4. Enter your age and gender.
5. Click Continue if you accept the Terms and Conditions to chat with a nurse.

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 program physician or facility, sign on to 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
Maternity Support Program

The Maternity Support Program is an educational program for expectant mothers. It is based on the guidelines created by the American College of Obstetrics and Gynecology (ACOG). The program also assists in the early identification of women who are at increased risk for premature labor and premature delivery. The program encourages doctor-patient discussions and healthy behavior during pregnancy and provides information that will increase awareness of pregnancy-related issues. Features include:

- Pregnancy assessment to identify your special needs
- Access to experienced nurses for help with your questions and concerns
- Education and support for prenatal and postpartum care
- Identification of pregnancy risk factors and enhanced health care needs
- Health education materials concerning your pregnancy
- Information about your baby's and your own health care needs after delivery
- Referrals to UnitedHealthcare’s Custom Personal Health Support program to help coordinate any additional services

To get the best possible benefit from this program, enrollment is encouraged in the first 12 weeks of pregnancy. You can enroll anytime up to your 34th week of pregnancy.

To enroll, call the UnitedHealthcare customer service number printed on your member ID card. Call between the hours of 8:00 a.m. and 8:00 p.m. Central Time, Monday through Friday, and ask to talk to a Maternity Support Nurse. Participation in the Maternity Support Program does not qualify as authorization for medical services under the Plan.

What the Plan covers

The Plan covers certain treatments for illness, injury, and pregnancy. (See the “Covered health services” section on page 10 for more detail.) Coverage is not necessarily limited to services and supplies described in this section, but do not assume that 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 definition 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.

Acupuncture

After you satisfy the deductible, you pay coinsurance. The 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 30.

Ambulance

After you satisfy the deductible, you pay coinsurance.

- Ambulance service to and from a local hospital required for stabilization and initiation treatment as provided under the direction of a physician.
- 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 (see the “Exceptions to the UnitedHealthcare notification process” section on page 14).

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

Not covered:
- 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 30.

Bariatric services
See the “Morbid obesity” section on page 22.

Chiropractic care
See the “Spinal treatment” section on page 26.

Dental care
After you satisfy the deductible, you pay coinsurance. The Plan covers certain medically necessary hospital services (see the “Covered health services” section on page 10) for dental care. This is 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:
  - 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
  - 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 services are determined based on established medical policies as determined by UnitedHealthcare, which are subject to periodic review and modification by the medical directors.

The 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 25 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 noted above
  - Oral appliances except as needed for medical conditions affecting temporomandibular joint dysfunction (TMJ); see the “Temporomandibular joint dysfunction (TMJ)” section on page 27
- Oral surgery, and all associated expenses, including hospitalizations and anesthesia, except as noted above
• Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums, and all associated expenses, including hospitalizations and anesthesia, except as noted above
• Treatment of a congenitally missing, malpositioned, or supernumerary tooth, even if part of a congenital anomaly, and all associated expenses, including hospitalizations and anesthesia, except as noted above

Also, refer to the “What is not covered” section on page 30.

**Durable medical equipment, prosthetics, and supplies**

**Durable medical equipment and supplies**
After 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, and devices cannot be consumable or disposable
- Cannot be used by a person in the absence of a disease or disability
- For orthotic appliances and devices, the items must be custom-manufactured or custom-fitted to the patient for diagnosed condition

If more than one piece of durable medical equipment or prosthetic device can meet your functional needs, benefits are available only for the most cost-effective piece of equipment, as determined by UnitedHealthcare. The Plan provides benefits for a single purchase, including repairs, of a type of prosthetic device every three calendar years. Benefits are provided for the replacement of each type of prosthetic device if there is a change in the covered person’s medical condition which requires repair/replacement sooner (e.g., due to growth of a dependent child).

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). Covered durable medical equipment:

- Shoe orthotics for foot amputees only
- Insulin pumps
- Wheelchair

The Plan also provides benefits for the replacement of a type of durable medical equipment once every three calendar years, unless there is a change in the covered person’s medical condition which requires repair/replacement sooner (e.g., due to growth of a dependent child).

Not covered:
- Appliances for snoring
- Devices used specifically as safety items or to affect performance in sports-related activities
- Eyeglasses, contact lenses (except as noted above)
- Fitting charge for hearing aids, eyeglasses, or contact lenses
• Hearing aids or assisted hearing devices (except as noted in the “Hearing aids” section on this page)
• Prescribed or nonprescribed medical supplies and disposable supplies, including elastic stockings, ace bandages, gauze, and dressings
• Cranial bands and cranial banding
• Items that can be obtained without a prescription or physician’s order
• Orthotics (except as noted above)
• 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, and home remodeling to accommodate a health need (such as ramps and swimming pools) and vehicle enhancements
• Tubings, nasal cannulas, connectors, and masks are not covered except when used with durable medical equipment
• Oral or dental prosthesis
Also, refer to the “What is not covered” section on page 30.

Emergency care
After you satisfy the deductible, you pay coinsurance.

• 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 covered health services

See the “Exceptions to the UnitedHealthcare notification process” section on page 14.
For exceptions, refer to the “What is not covered” section on page 30.

Hearing aids
After you satisfy the deductible, you pay coinsurance. One hearing aid or one set of hearing aids is covered every three calendar years for dependents up through the calendar year in which the child turns age 18.

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 associated with fitting and testing.

Home health care
After you satisfy the deductible, you pay coinsurance. You must notify UnitedHealthcare before you receive services. The Plan covers some home health care as an alternative to hospitalization. In any calendar year, the Plan covers up to 100 visits (network and out-of-network combined) that are considered covered health services (100 visits are combined with home health care and extended skilled nursing). One visit equals up to four hours of care services. All services under this benefit must be preauthorized by UnitedHealthcare to be eligible for coverage.

Covered home health care includes services that are ordered by a physician and provided by or supervised by a registered nurse in your 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.

UnitedHealthcare must be notified before receiving services.

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.

Also, refer to the “What is not covered” section on page 30.
Extended skilled nursing care
After 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.
- The covered person and the provider must obtain prior authorization from the Plan (contact Member Services of the Plan to request prior authorization).

Benefits are limited to 100 visits (in network and out of network combined) 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:

1. Transition of the covered person from an inpatient setting to home.
2. The covered person becomes acutely ill and the additional skilled nursing care will prevent a hospital admission.
3. 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.
4. 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.

Hospice care
After 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 comfort and support services for the terminally ill. It includes physical, psychological, social, and spiritual care for the terminally ill patient (prognosis of six months or less) and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.

The Plan includes coverage for:
- Palliative care
- Inpatient care
- Physician services
- In-home health care services, including nursing care, use of medical equipment, wheelchair and bed rental, and home health aide care
- Emotional support services
- Physical and chemical therapies
- 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 30.
Hospital inpatient services
After you satisfy the deductible, you pay coinsurance. UnitedHealthcare notification is required before receiving hospital inpatient services. Hospital costs that are covered include:

- 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 admitted 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
- 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.
- Intensive care and cardiac care
- Miscellaneous hospital services and supplies except as noted below, including operating room
- Semiprivate room and board
- X-ray and lab services, drugs, and anesthetics and their administration

See either the “Using the Choice Plus network” section on page 12 or the “Custom Personal Health Support” section on page 12.

Not covered:

- Admission for diagnostic tests that can be performed on an outpatient basis
- Comfort or convenience items such as television, telephone, beauty and barber service, or guest service
- Late charges for less than a full day of hospital confinement, if for patient convenience
- Miscellaneous hospital expenses such as admission kits
- Private duty nursing in a hospital (see the “Extended skilled nursing care” section on page 20 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 30.

Infertility treatment
After 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:

- Fees or direct payment for sperm or ovum donations.
- Health services and associated expenses for infertility treatments, except artificial insemination.
- In vitro fertilization, GIFT, and ZIFT, and related charges are specifically excluded from coverage.
- Monthly fees for maintenance and the storage of sperm, ovum, or frozen embryos.
- Reversal of voluntary sterilization and treatment of infertility after reversal of voluntary sterilization and any related charges incurred for these excluded services.
- A surrogate’s pregnancy on your behalf and related obstetric and maternity benefits.
- Prescription drugs for the treatment of infertility.

Also, refer to the “What is not covered” section on page 30.

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

There is a special prenatal program available to participants during pregnancy. It is voluntary and there is no extra cost for participating in the program. Refer to the “Maternity Support Program” section on page 16 for information.
The Plan will pay benefits for the covered mother and the newborn (the child must be added to your coverage through Wells Fargo — 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 for either:

• 48 hours for the mother and newborn child following a normal delivery
• 96 hours for the mother and newborn child following a cesarean section delivery

Your provider does not need authorization from the Plan to prescribe a hospital stay of this length. However, additional days beyond 48 or 96 hours require authorization.

You must notify UnitedHealthcare as soon as reasonably possible if the inpatient stay for the mother, the newborn, or both will be more than the minimum stays described above. 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 24 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 30.

**Morbid obesity**

After 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 surgery and 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 Bariatric Resource Services at 1-888-936-7246 to determine if they meet criteria to enroll in the program. This comprehensive program requires that 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, a 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 Center of Excellence facility are not covered and no benefits will be paid. A designated Center of Excellence provider or facility may or may not be located within your geographic area. Depending on the location of this 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, transplants, transgender, cancer, and CHD services” section on page 30 are covered health services only in connection with the program’s morbid obesity bariatric services received from a designated provider at a designated facility after enrollment in the program. Contact OptumHealth for more information.

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.

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
• Repeat weight loss surgery, defined as any second or subsequent procedure performed, regardless of type of weight loss surgery performed, and regardless of coverage at the time of the previous procedure
• Experimental, investigational, or unproven services
Nutritionists

After 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 there exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional. 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 (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 30.

Nutritional formulas

After you satisfy the deductible, you pay coinsurance. The Plan covers nutritional formulas only when used as the definitive treatment of an inborn metabolic disorder, such as phenylketonuria (PKU).

Not covered:

- Diets for weight control or treatment of obesity (including liquid diets or food)
- Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements (except when used as the definitive treatment of an inborn metabolic disorder, such as PKU)
- Food, food substitutes, or food supplements of any kind (diabetic, low fat, cholesterol, infant formula, etc.)
- 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
- Oral vitamins and oral minerals

Also, refer to the “What is not covered” section on page 30.

Outpatient surgery, diagnostic, and therapeutic services

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

- Diabetes outpatient self-management training and education, including medical nutrition therapy
- Kidney dialysis (both hemodialysis and peritoneal dialysis)
- Lab
- X-ray*
- Mammography testing
- Radiation and chemotherapy
- CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services*
- Covered health services, including 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
- 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 21.

* 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 30.

**Physician services**

After you satisfy the deductible, you pay coinsurance. If you are enrolled in the PPO Plan, your primary care physician will provide you with services or refer you to a specialist if necessary. If you use an out-of-network provider without authorization from UnitedHealthcare or you use out-of-network providers or Indemnity providers, you must complete the UnitedHealthcare notification process before receiving services to receive the highest level of benefits. (See either the “Using the Choice Plus network” section on page 12 or the “Custom Personal Health Support” section on page 12.)

Physician services include:

- Allergy testing, serum, and injections
- Genetic testing for diagnostic procedures only
- 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

- 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
- Services of a Christian Science practitioner or a Christian Science nurse, except as listed in the “Hospital inpatient services” section on page 21
- 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 30.

**Preventive care services**

The Plan covers in-network, eligible preventive care services at 100%. When using out-of-network providers, eligible preventive care services are not subject to the out-of-network deductible and 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 non-routine, 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 non-routine (i.e., office visit, lab work, tests or procedures).

You may be required to pay your annual deductible or coinsurance if you receive eligible preventive care services at the same time you receive certain services that are not considered eligible preventive care services. 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 non-preventive care office visit. You would then be responsible for the non-preventive care annual deductible or coinsurance amount. However, the provider may submit separate claims for the preventive and non-preventive 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 a non-preventive care service, or the provider may submit separate claims for the preventive and non-preventive 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.

Reconstructive surgery
After you satisfy the deductible, you pay coinsurance. The Plan covers certain reconstructive procedures when preauthorized by UnitedHealthcare (contact UnitedHealthcare). Refer to the “Custom Personal Health Support” section on page 12 for authorization procedures. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part to address one of the following:
• For prompt repair of accidental injury that occurs while covered under the Plan
• To improve function of a malformed body part
• To correct a defect caused by infection or disease

The 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 Plan provisions continue to apply. The same annual deductibles and coinsurance provisions that apply to the mastectomy surgery apply to postmastectomy reconstructive surgery. 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 17

Skilled nursing facility
After you satisfy the deductible, you pay coinsurance. The Plan covers services for an inpatient stay in a skilled nursing facility or acute inpatient rehabilitation facility. Contact UnitedHealthcare for authorization before receiving services. Benefits are limited to 100 days per calendar year (network and out-of-network combined). 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 or rehabilitation services 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 enteral 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 in order to be delivered safely and effectively.
• Private duty nursing (see the “Extended skilled nursing care” section on page 20 for more information).

Also, refer to the “What is not covered” section on page 30.

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

Not covered:
• Therapy, service, or supplies, including but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition,
where the treatment ceases to be therapeutic, 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 30.

**Temporomandibular joint dysfunction (TMJ)**

After you satisfy the deductible, you pay coinsurance. With preauthorization, the Plan covers treatment of medical conditions affecting the temporomandibular joint when provided by or under the direction of a physician. The initial evaluation is covered to obtain the diagnosis. 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 you satisfy the deductible, you pay coinsurance. The Plan provides benefits for the following types of outpatient services:

• Cardiac rehabilitation therapy (preauthorization is required; contact UnitedHealthcare)
• Pulmonary rehabilitation therapy
• Physical therapy
• Occupational therapy
• Speech therapy

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, in network and out of network combined 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.

Habilitative 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 UnitedHealthcare criteria guidelines
• Speech 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
• 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
• Physical therapy, occupational therapy, and speech therapy in excess of annual limit of 90 visits combined
• Hippotherapy
• Prolotherapy
• Eye exercise or vision therapy

Also, refer to the “What is not covered” section on page 30.

**Transgender surgery benefits**

After you satisfy the deductible, you pay coinsurance. The Plan covers many of the charges incurred for transgender surgery (also known as gender reassignment surgery) for covered persons who meet all of the conditions for coverage listed below as determined by UnitedHealthcare. Transgender surgery benefits are limited to one gender reassignment 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**
- Pre- and postsurgical hormone therapy covered under pharmacy benefit
- Surgery, subject to the requirements outlined in the “Conditions for coverage” section below

**Conditions for coverage**
To receive benefits, the patient must:
- Notify UnitedHealthcare as soon as the need for a transgender surgical benefit arises.
- Be at least 18 years of age.
- Have undergone continuous hormonal therapy — usually for 12 months — with 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.

**Transgender surgery exclusions**
- Any transgender surgery or related services for a covered person who does not meet all of 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, transplants, transgender, cancer, and CHD services” section on page 30 for information about covered travel expenses.

**Voluntary transplant program**

**Organ or tissue transplants**
After you satisfy the deductible, you pay coinsurance. Covered services and supplies for the following organ or tissue transplants are payable under this 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.
- Transplant procedure.
- 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 this 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 transplant facility.

If a qualified procedure is a covered health service and performed at a designated transplant facility, the medical care and treatment provisions and the transportation and lodging provisions apply.

Qualified procedures:
- Heart transplants
- Lung transplants
- Heart and lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants
- Kidney and pancreas transplants
- Bone marrow or stem cell transplants
• Other transplant procedures when UnitedHealthcare determines that it is medically necessary to perform the procedure at a designated transplant 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 or 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.

Not covered:
• Health services for organ and tissue transplants, except those described above
• Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are payable for a transplant through the organ recipient’s benefits under the Plan)
• Health services for transplants involving mechanical or animal organs
• Any solid organ transplant that is performed as a treatment for cancer
• Any multiple organ transplant not listed as a covered health service
• Travel and lodging expenses for patients not working with UnitedHealthcare
• Purchase of human organs that are sold rather than donated

Also, refer to the “What is not covered” and the “Transportation and lodging for bariatric, transplants, transgender, cancer, and CHD services” sections on page 30.

Cancer Resource Services
Custom Personal Health Support will arrange for access to a designated facility participating in the Cancer Resource Services (CRS) program for the provision of oncology services. The oncology services include covered services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology. 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.

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 PPO 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).

Congenital heart disease services
Congenital heart disease (CHD) 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 CHD 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 CHD services, including outpatient diagnostic testing, in utero services and evaluation, including:
• CHD surgical interventions
• Interventional cardiac catheterizations
• Fetal echocardiograms
• Approved fetal interventions

The services described in the “Transportation and lodging for bariatric, transplants, transgender, cancer, and CHD services” section below are covered health services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

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.

**Transportation and lodging for bariatric, transplants, transgender, cancer, and CHD services**

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 notification, expenses for travel and lodging for the covered person and a companion are available under this 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 after discharge 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

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**What is not covered**

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

**Alternative treatment**

Acupressure, aromatherapy, hypnotism, massage therapy, rolfing, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health are not covered.

**Experimental, investigational, or unproven services**

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**

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**

Services provided:

- 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 to each other, and the patient is not allowed to choose which treatment is received.

Well-conducted cohort studies. Patients who receive study treatment are compared to a group of patients who 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, where services 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, flexibility, and diversion or general motivation.
- Weight loss programs, services, supplies, and treatment, whether or not they are under medical supervision or for medical reasons (except as noted in the “Morbid obesity” section on page 22).
- Treatment, services, or supplies for unwanted hair growth or hair loss.
- Wigs, regardless of the reason for the hair loss.
- Sclerotherapy as stand-alone treatment of varicose and spider veins, or in the absence of prior consistent conservative treatment, ligation, or stripping.
- Laser therapy treatment for acne and other skin conditions.
- Laser treatment for veins when done for improvement in appearance or for cosmetic purposes.

**Providers**

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, child, aunt, uncle, cousin, grandparent, and step-relative, including any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence.

**Services provided under another plan**

- 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.
- Health services while on active military duty.
- Charges payable under Medicare.

**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 and Centers of Excellence may be reimbursed at the claims administrator’s discretion.

**All other exclusions**

- Braces that straighten or change the shape of a body part, except as noted under durable medical equipment provisions.
- Communication charges, such as telephone calls in connection with treatment by a Christian Science Practitioner who is not present.
- Health services and supplies that do not meet the definition of a covered health service (see the “Covered health services” section on page 10).
- 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 primary payer over this Plan.
- Charges a network provider is required to write off.
- Accidents or injuries incurred while self-employed or employed by someone else for wages or profit, including farming.
• Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when:
  – Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage, or adoption
  – Related to judicial or administrative proceedings or orders
  – Conducted for purposes of medical research
  – Required to obtain or maintain a license of any type
• Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
• Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
• In the event that an out-of-network provider waives any portion of the charges for a particular health service, no benefits are provided.
• Charges in excess of eligible expenses or in excess of any specified limitation.
• Private room charges when facility has a semiprivate room available.
• Respite care.
• Rest cures.
• Psychosurgery.
• Treatment of benign gynecomastia.
• Surgical treatment of excessive sweating (hyperhidrosis) unless a predetermination by UnitedHealthcare determines the prescribed treatment is a covered benefit.
• Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
• Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing.
• Child care costs, including day care centers and individual child care.
• Any charges higher than the actual charge; the actual charge is defined as the provider’s lowest routine charge for the service, supply, or equipment.
• 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 prohibited by federal anti-kickback or self-referral statutes.
• Any additional charges submitted after payment has been made and your account balance is zero.
• Any charges by a resident in a teaching hospital where a faculty physician did not supervise services.
• Pastoral counselors.
• Any charges for a stand-by provider or facility when no actual services have been performed.
• Treatment provided in connection with tobacco dependency.
• Charges for services needed because the patient was engaged in an illegal activity when the injury occurred.
• Educational services, except for nutritional counseling as noted in the “Nutritionists” section on page 23.
• Growth hormone therapy.
• Surgical treatment of obesity, except as previously noted under the “Morbid obesity” section on page 22.
• Routine vision services.
• 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)
• Interest or late fees charged due to untimely payment for services.
• Charges for or associated with patient advocacy.
• Comfort or convenience items.
• Laser therapy for acne and other skin conditions.
• Sclerotherapy as stand-alone treatment of varicose and spider veins, or in the absence of prior consistent conservative treatment, ligation, or stripping.
• Fitting charges for hearing aids, assistive devices, amplifiers, eyeglasses, and contact lenses.
• Hippotherapy.
• Prolotherapy.
• VNS therapy.
• Vision correction surgery including radial keratotomy, laser, and other refractive eye surgery.
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 that 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 that 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 patient 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 informally contact Member Services before filing a formal appeal. For more information, see the “Contacts” section on page 1.

You may also file a formal written appeal with UnitedHealthcare without first informally contacting Member Services. A written 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.”
Third-party liability

The Plan does not cover medical expenses that you (or your covered dependents) incur as a result of an injury or other medical condition caused by a third party. The Plan does not provide benefits to the extent that there is other coverage under nongroup health plan coverage (such as auto insurance). There are two methods the Plan may use to recover the value of the medical benefits paid for or provided to you in the event you have an injury or other medical condition caused by a third party. All references to “you” include both you and your covered dependents.

Reimbursement

This method applies when you receive damages by settlement, verdict, or from an insurance company or otherwise, for an injury or other medical condition caused by a third party. The 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 Plan may, however, advance payment to you for these medical expenses if you, or any person claiming through or on your behalf, agree:

• To grant to the Plan a first priority lien against any proceeds of any settlement, verdict, or insurance payments you receive as a result of the third party’s actions
• That the lien constitutes a charge upon the proceeds of any recovery and the Plan is entitled to assert a security interest on the lien
• That by accepting benefits under the Plan you will hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on your behalf
• To assign to the Plan any benefits you may receive under any automobile policy or other insurance coverage, to the full extent of the Plan’s claim for reimbursement

You must sign and deliver to the 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 Plan’s right to reimbursement. Reimbursement will be made regardless of whether you are fully compensated, and this right of recovery will not be defeated or reduced by the application of any so-called “Make Whole Doctrine” or any such doctrine purporting to defeat the Plan’s recovery rights by allocating proceeds exclusively to nonmedical damages. In addition, the Plan will recover the full amount regardless of any claim of fault on your part, whether under comparative negligence or otherwise. The 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.

By allowing the Plan to advance and, therefore, accepting the Plan’s advance payment of benefits on your behalf, you agree that you will not make any settlement that specifically reduces or excludes or attempts to reduce or exclude payment amount provided by the Plan on your behalf. If you refuse to fully reimburse the Plan after receipt of a settlement, verdict, or insurance proceeds, the Plan will not pay for any future medical expenses, whether anticipated or unanticipated, relating to your injury or medical condition. In addition, the 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 Plan any money you receive through a settlement, verdict, or insurance proceeds. At its sole discretion, the Plan also has the option of directly asserting its rights against the third party through subrogation. This means that the 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 Plan. The Plan may assert this right independently of you.

You agree to cooperate with the Plan and its agents in order to protect the Plan’s subrogation rights. Cooperation means providing the Plan or its agents with any relevant information as requested, signing and delivering such documents as the Plan or its agents request to secure the Plan’s subrogation claim, and obtaining the 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 Plan. Any costs incurred by the Plan in matters related to subrogation will be paid for by the Plan. The costs of legal representation you incur will be your responsibility.
Right of recovery

The UnitedHealthcare PPO 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 PPO calendar year. Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

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

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

If the UnitedHealthcare PPO Plan provides an advancement of benefits to you or your dependent: (a) before you meet the annual deductible and/or (b) meeting the coinsurance maximum for the calendar year, the UnitedHealthcare PPO Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The UnitedHealthcare PPO 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 PPO Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the UnitedHealthcare PPO Plan

Coordination of benefits — UnitedHealthcare PPO

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 (COB). Please note the following:

- There is no COB 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 on the Preferred
Drug List, is covered by the Plan, or is subject to certain
Plan provisions, visit medco.com or call Medco Member
Services at 1-800-309-5507 to obtain information about
this 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 choose
a drug from the Preferred Drug List or 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 41 for more information.

Bring your Medco ID card and pay your portion,
as shown in the “What you’ll pay for prescriptions”
table on page 40 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 41 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.
If it’s a covered expense, Medco will reimburse you, as
shown in the “What you’ll pay for prescriptions” table
on page 40, up to a 30-day supply per prescription.

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 1-800-309-5507.
• 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
1-800-309-5507.

With Medco By Mail you get:
• Up to a 90-day supply of covered drugs
• 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. If you are a first-time visitor, you’ll need to register using your Medco ID number (shown on your Medco 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 Medco 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.

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**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 are 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, lancets
- Insulin, insulin pen, insulin prefilled syringes, needles, and syringes for self-administered injections

The list of preferred drugs, 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.

**Diabetic supplies**

You can purchase drugs and supplies to control your diabetes for one copay or coinsurance amount, at mail order, when you submit prescriptions for the diabetic supplies at the same time as your prescription for insulin or oral diabetes medication. Common diabetic supplies include lancets, test strips, and syringes or needles. The copay or coinsurance amount you pay will depend on the type of diabetes medication prescribed.

Send the prescriptions for your drugs and supplies together in one envelope and note that the insulin or oral drug should be entered in the system first.

If you purchase diabetic supplies at a retail pharmacy, separate copays or coinsurance amounts will apply to each item.
Preferred Drug List
Certain prescription drugs are preferred, because they help control rising prescription drug costs and are high-quality, effective drugs. This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. The Preferred Drug List is reviewed and updated regularly by an independent pharmacy and therapeutics committee to ensure that it includes a wide range of effective generic and brand-name prescription drugs. The list is continually revised to ensure that the most up-to-date information is taken into account. Go to medco.com to see if your prescription is on the list.

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**

Here’s a snapshot of what you’ll pay depending on the type of drug and where you get it.

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Network retail pharmacy</th>
<th>Out-of-network retail pharmacy</th>
<th>Medco By Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Up to a 30-day supply)</td>
<td>(Up to a 30-day supply)</td>
<td>(Up to a 90-day supply)</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>You pay a $5 copay.</td>
<td>You pay a $5 copay + (full cost – Medco discounted amount).</td>
<td>You pay a $10 copay.</td>
</tr>
<tr>
<td>Preferred brand-name drugs</td>
<td>You pay 30% of covered charges with $80 maximum per prescription.</td>
<td>You pay 30% of covered charges with $80 maximum per prescription + (full cost – Medco discounted amount).</td>
<td>You pay 30% of covered charges with $90 maximum per prescription.</td>
</tr>
<tr>
<td>Nonpreferred brand-name drugs</td>
<td>You pay 40% of covered charges with $90 maximum per prescription.</td>
<td>You pay 40% of covered charges with $90 maximum per prescription + (full cost – Medco discounted amount).</td>
<td>You pay 40% of covered charges with $140 maximum per prescription.</td>
</tr>
<tr>
<td>Maximum annual out of pocket for prescriptions</td>
<td>NA</td>
<td>NA</td>
<td>$1,000 per individual and $2,000 per family — mail only</td>
</tr>
</tbody>
</table>

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 generic equivalent for brand-name drugs whenever possible.
- If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copay, plus the difference in cost between the brand-name drug and the generic drug. Any difference in cost between the brand and generic is not applied to any maximum per prescription amount listed above. At mail order, the difference in cost that you pay is not applied to the annual out-of-pocket maximum. If your doctor requests the brand-name drug (i.e., because it is medically necessary), you will pay the nonpreferred brand-name drug coinsurance amount.
- There are no exceptions to any of the copay or coinsurance amounts listed above, even with a physician’s request. For example, if the drugs on the preferred list are not appropriate for you and you choose a drug that’s not on the list, you will still have to pay the higher copay or coinsurance amount.

- Prescriptions for certain specialty drugs (typically self-injectables) cannot be filled at retail pharmacies. For more information, see the “Specialty care pharmacy” section on page 41.
- 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 41.
Your ID card

Shortly after you enroll in the Plan, you’ll receive an ID card from Medco. 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 Medco Member Services at 1-800-309-5507 to get your Medco 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.

If you do not have a Medco ID card, after you have your Medco identification number from Member Services, go to medco.com to print a temporary ID card.

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 are 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 1-800-309-5507 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), 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 will be responsible for the full cost of the medication. 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., Solodyn®)
• Acathar® 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®)
• Severe plaque psoriasis drugs (e.g., Stelera®)
• Pain management (e.g., Lidoderm® patches)
• Paroxymal Nocturnal Hemoglobinuria (PNH) agents (e.g., Soliris®)
• Phenylketonuria agents (e.g., Kuvan®)
• 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®, Remica®d®, Orenica®, 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®, or 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 Acipex®, Dexilant™, lansoprazole (generic Prevacid®), pantoprazole (generic Protonix®), Prevacid®, Prilosec®, Protonix®, or Zegrid®.

• **Blood pressure medications.** You may need to try generic Cozaar®, Hyzaar®, Diovan®, Diovan HCT®, Micards®, or Micards HCT® before the Plan will cover Atacand®, Atacand HCT®, Avapro®, Avalide®, Benicar®, Benicar HCT®, Teveten®, or Teveeteen HCT®.

• **Sleep aids.** You may need 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 fluticasone propionate (generic Flonase®), generic flunisolide (generic Nasarel®), or Nasacort® 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 (e.g., Valtrex®, Zovirax®)
• Antiemetic agents (e.g., Zofran®, Kytril®)
• Migraine therapies (e.g., Imitrex®, Imitrex®NS, Zomig®, Zomig-ZMT®)
• Oral bronchdilators (e.g., Albuterol®, Alupent®, Brethaire®, Maxaire®, Proventil®)
• Oral inhaled steroids (e.g., Advair®, Aerobid®, Azmacort®, Beclovent®, Flovent®, Pulmicort®, Qvar®, Vanceril®)
• Pain medications (e.g., Actiq®, Fentora®)
• Sleeping medications (e.g., 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., Spranox®, 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., antiwrinkle 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 1-800-309-5507. 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 PPO 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 Vivotif 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 1-800-309-5507.

Out-of-pocket maximums

If you use Medco By Mail, a $1,000 individual or $2,000 family out-of-pocket maximum applies. However, there’s no out-of-pocket maximum for retail pharmacy purchases.

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 before you can 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 Inc.
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 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 informally by contacting Medco Member Services. An appeal must be filed within 180 days from the date of the adverse determination for 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 this 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 PPO Plan, you and your covered dependents have coverage for in- 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 PPO 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 and 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 table is subject to the limits and exclusions noted in this chapter. The annual deductible and annual out-of-pocket maximum apply and are combined with the medical plan. Please see the “Your benefits and costs at a glance” chart on page 7 for more information.

Coverage for in-network or out-of-network mental health and substance abuse services is available.

<table>
<thead>
<tr>
<th>Plan features: MHSA in the UHC PPO Plan</th>
<th>You pay in network</th>
<th>You pay out of network* (if you reside in the UHC network but use out-of-network UBH providers)</th>
<th>Indemnity benefits** (if you reside outside the UHC network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% of eligible covered expenses after the deductible</td>
<td>40% of eligible covered expenses after the deductible</td>
<td>20% of eligible covered expenses after the deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% of eligible covered expenses after the deductible</td>
<td>40% of eligible covered expenses after the deductible</td>
<td>20% of eligible covered expenses after the deductible</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>20% of eligible covered expenses after the deductible</td>
<td>40% of eligible covered expenses after the deductible</td>
<td>20% of eligible covered expenses after the deductible</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% of eligible covered expenses after the deductible</td>
<td>40% of eligible covered expenses after the deductible</td>
<td>20% of eligible covered expenses after the deductible</td>
</tr>
<tr>
<td>Structured outpatient</td>
<td>20% of eligible covered expenses after the deductible</td>
<td>40% of eligible covered expenses after the deductible</td>
<td>20% of eligible covered expenses after the deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% of eligible covered expenses after the deductible</td>
<td>40% of eligible covered expenses after the deductible</td>
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</tr>
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<td>Partial hospitalization</td>
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<td>40% of eligible covered expenses after the deductible</td>
<td>20% of eligible covered expenses after the deductible</td>
</tr>
</tbody>
</table>

For preauthorization, contact UHC at 1-800-842-9722.

* Out-of-network benefits determined using UBH 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 UHC 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 19 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 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 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 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 PPO Plan” starting on page 5 and “Chapter 3: Prescription drug benefit” starting on page 37 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 20 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, rolffing, 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 UHC/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 informally 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 about claims and appeals is provided in the Benefits Book, “Appendix A: Claims and appeals.”