MN017-E-200 PO Box 1459 Minneapolis, MN 55440-1459

Annual Member Notice

December 2019

Language Assistance Services

We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 7 a.m. to 10 p.m. CST.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ភាសាខ្មែរ (Khmer)

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរសេវាជំនួយភាសាដោយឥតគិតថ្លៃគឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខប័ណ្ណសមាជិកឥតគិតថ្លៃ ដែលមាននៅលើប័ណ្ណ ID របស់អ្នក។

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στο δελτίο ταυτότητας μέλους.

P AKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinigíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե **հայերեն (Armenian)** եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանապարհային քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ **ਪੁਞ੍ਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ 'ਤੇ ਕਾੱਲ ਕਰੋ।

โปรดทราบ: หากคุณพูด**ภาษาไทย (Thai)** มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวของคุณ

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

Note for Members in California: To register your primary spoken and written languages, please call the toll-free member phone number on your health plan ID card. If you have already contacted us with this information or if your primary language is English, you don't need to contact us again.

Nota para Miembros en California: Para registrar sus principales idiomas escritos y hablados, llame al número de teléfono gratuito para miembros que figura en el reverso de su tarjeta de identificación. Si ya se comunicó con nosotros para brindarnos esta información o si su idioma principal es el inglés, no es necesario que vuelva a comunicarse con nosotros.

加州會員注意事項：如欲登錄您主要的口頭及書面語言，請撥打您會員卡背面的免付費會員電話號碼。若您已提供此項資訊，或您的主要語言為英文，則無需再次與我們聯絡。

Assistance for members with hearing impairments

If you have a hearing impairment and need to contact us or nurses in Clinical Services, TTY users can dial 711 and provide the the toll-free member phone number on your ID card.

Nondiscrimination Notice

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through a UnitedHealthcare company, Neighborhood Health Partnership, Inc., UnitedHealthcare of Alabama, Inc., UnitedHealthcare of Arizona, Inc., UnitedHealthcare of Arkansas, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Florida, Inc., UnitedHealthcare of Georgia, Inc., UnitedHealthcare of Illinois, Inc., UnitedHealthcare of Kentucky, Ltd., United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid- Atlantic, Inc., UnitedHealthcare of the Midlands, Inc., UnitedHealthcare of the Midwest, Inc., United HealthCare of Mississippi, Inc., UnitedHealthcare of New England, Inc., UnitedHealthcare of North Carolina, Inc., UnitedHealthcare of Ohio, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Tennessee, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., UnitedHealthcare of Wisconsin, Inc., or UnitedHealthcare Plan of the River Valley, Inc.

Getting the Most From Your Health Care Coverage

This guide is designed to help you get the most from your health plan benefits.[1] We work with the National Committee for Quality Assurance® (NCQA®) and state and federal regulators to ensure members receive this information on an annual basis.

Important note: Not all information provided in this document is applicable to all enrollees. Some information may not apply if your plan does not provide certain coverage, products and/or services referenced herein. Your plan document (Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage), including all of its Riders, amendments or summary of material modifications, contains a complete listing of the terms and conditions of your coverage and prevails in the event of any conflict between this document and your plan document.

In addition, information in this document is current as of the date of issue and may be subject to change at any time due to employer-directed plan changes, state mandates and federal laws. Please refer to your plan document for specific information on your benefits or refer to your member website for the most up-to-date information.

Getting Answers to Your Questions

Information about your health care benefits is just a click or phone call away.

Sign in to **myuhc.com**® for personalized information and helpful tools to help you manage your health and your health care dollars.

- ***Coverage & Benefits*:** Learn whether a service is included or excluded from coverage and if notification is required, the coverage levels for different types and places of care, and your copayment, coinsurance and deductible amounts (as applicable).
- ***Claims & Accounts*:** Check your claims status and find out what has been paid and the amount you are responsible for paying. If you use our network of providers, you won't have to submit a claim.There's also information on how to submit an appeal if you disagree with our payment decision.
- ***Find Care & Costs*:** Find a network facility, doctor or other healthcare provider. You can also calculate the approximate cost of health care services in your area.
- ***Pharmacies & Prescriptions*:** get pharmacy benefit information including notification requirements, supply limits or step therapy requirements, if applicable. You can also price medications, look for lower-cost alternatives, locate a network pharmacy, refill prescriptions, or check the status of your order at our Mail Service Pharmacy.[2]
- ***ID cards*:** Print a temporary health plan ID card or order a replacement.

[1]Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through a UnitedHealthcare company, Neighborhood Health Partnership, Inc., UnitedHealthcare of Alabama, Inc., UnitedHealthcare of Arizona, Inc., UnitedHealthcare of Arkansas, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Florida, Inc., UnitedHealthcare of Georgia, Inc., UnitedHealthcare of Illinois, Inc., UnitedHealthcare of Kentucky, Ltd., United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid- Atlantic, Inc., UnitedHealthcare of the Midlands, Inc., UnitedHealthcare of the Midwest, Inc., United HealthCare of Mississippi, Inc., UnitedHealthcare of New England, Inc., UnitedHealthcare of North Carolina, Inc., UnitedHealthcare of Ohio, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Tennessee, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., UnitedHealthcare of Wisconsin, Inc., or UnitedHealthcare Plan of the River Valley, Inc.

[2]For plans that include pharmacy benefits provided by UnitedHealthcare or OptumRx.

If you do not have access to the Internet or need to contact us, call the toll-free member phone number on your health plan ID card, TTY 711, or email us at Advocate4Me@uhc.com.[3]

The UnitedHealthcare® app makes it easy to find nearby doctors, check the status of a claim, see your account balance or view your ID card. You may even be able to video chat with a doctor—all from your smartphone or tablet.[4]

Clinical Services

Clinical Services is a department within UnitedHealthcare that includes our notification unit and inpatient and outpatient care programs. If you have questions about a preauthorization (coverage approval) or your use of medical services, call the toll-free phone number on your health plan ID card, TTY 711. Language assistance is also available at this same toll-free number.

Questions or concerns about benefit determinations

If you have questions or concerns about how a benefit coverage decision was determined, call the member phone number on your health plan ID card. If we cannot resolve the issue to your satisfaction over the phone, or if you disagree with the determination and you wish to appeal the determination, ask for the appropriate address to which you can submit your written appeal request.

How to submit an appeal

The appeal process is outlined in your COC/Member Handbook and on every Explanation of Benefits (EOB)/Health Statement you receive from UnitedHealthcare for services provided by network and non-network providers.

When requesting an appeal of a benefit determination, include the following information:

- Patient's name and identification number from the health plan ID card
- The date(s) of medical service(s)
- The physician's/health care professional's/facility's name
- The reason you believe the claim or benefit should be paid
- Any documentation or other written information to support your request for claim payment or benefit coverage

Your first appeal request must be submitted to UnitedHealthcare within 180 days (or longer where required by state law) after you receive the coverage denial or an adverse determination. You or your authorized representative may submit any written comments, documents, records, or other information you feel is relevant. You have the right, upon request and free of charge, to receive reasonable access to and copies of all documents, records and other information relevant to your claim benefits. If someone submits an appeal on your behalf, we may require written authorization from you allowing that person to act as your authorized representative.

[3]Advocate4Me services should not be used for emergency or urgent care needs. In an emergecny, call 911, or go to the nearest emergency room. To help protect your privacy, please do not include confidential information in your first email. We will respond to your question using a secure email system.

[4]The UnitedHealthcare® app is available for download for iPhone® or AndroidTM. iPhone is a registered trademark of Apple, Inc. Android is a trademark of Google LLC. Virtual Visits and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Data rates may apply.

All trademarks are the property of their respective owners.

External review program

If following completion of the internal appeal process, you remain dissatisfied with the outcome of a clinical review, you may have the right to an independent external review or IER.[5] This is when the appeal decision is made by an independent review organization—not by UnitedHealthcare.

For appeal decisions that are based on clinical factors, an independent medical expert will review the plan's decision within the framework of your benefits as stated in your COC/Member Handbook and applicable law, using documents provided during the internal review process while incorporating published, peer-reviewed clinical evidence.[6] UnitedHealthcare will use the decisions made by the independent review organization as the final coverage determination. This process provides you with a timely, fair and objective response to your health care coverage concerns without incurring unnecessary costs, lengthy delays, and consumption of resources. Please review your COC/Member Handbook, or appeal determination letters, for information about eligibility to appeal to an independent review organization.

How to submit a complaint

If you are dissatisfied with the handling of a claim processing issue by UnitedHealthcare or any other experience with UnitedHealthcare, you may file a complaint by calling the member phone number on your health plan ID card. UnitedHealthcare will investigate the issue and, in the case of a written complaint, provide a response in writing, including any corrective actions that may be taken to resolve the issue.

Getting the Right Care at the Right Place

UnitedHealthcare has one of the nation's largest single proprietary networks with over 900,000 doctors and health care professionals and over 6,000 hospitals. Our pharmacy network includes all the major national and regional pharmacy chains and most independent local pharmacies.

You get the highest level of plan benefit coverage when you choose facilities, doctors and other health care professionals that participate in your plan's provider network. **Services from nonnetwork providers may result in higher out-of-pocket cost for you—or may not be covered at all—depending on your plan.**

Some plans do not provide benefit coverage for care received outside the network. Check your plan coverage before selecting a physician or hospital.

For plans that include out-of-network coverage, in addition to your cost share, you may be required to pay any difference between the covered amount and the amount charged by the out-of-network provider.

If you need covered health care services that are not available from a network provider—or access to a network provider would require unreasonable delay or travel—you, your doctor or a representative acting on your behalf can ask for an exception or referral to an out-of-network provider. To request a referral to an out-of-network provider, call the toll-free member phone number on your health plan ID card. For mental health and substance use disorder services, call the Mental Health phone number on your ID card. If we confirm that care is not available from a network provider due to the reasons above, we will work with you and/or your network provider to coordinate care through an out-of-network provider.

[5]In Texas, Oklahoma, Oregon and Washington, this process is called an IRO – Independent Review Organization. In California, this process is called IMR – Independent Medical Review. In Arizona, this process is called EIR – External Independent Review. In Idaho and Nevada, this process is called External Review.

[6]For members in Arizona, the Arizona Department of Insurance may conduct the external review or make arrangements for independent physicians to conduct the external review.

Finding a network health care provider

Sign in to **myuhc.com** to find information on network doctors and other health care professionals who can meet your need for primary care, specialty care or behavioral health care, if applicable. You can search and filter by name, specialty, location and other options. Information on network hospitals and other health care facilities can also be found here. Always confirm the network participation of both the health care professional and the facility before receiving health care services.

If you are not able to view our online directory, or for more information on the professional qualifications of a network provider, call the member phone number on your health plan ID card. A customer service representative will help you or have a printed copy of the network directory sent to you.

Choosing a doctor is one of the most important health care decisions you'll make. The UnitedHealth Premium® designation makes it easier for you to find doctors who meet national standards for quality and local market benchmarks for cost efficiency.[7] Visit **myuhc.com** to find the doctor that is right for you.

Where to go for medical care

Your plan includes coverage for different types of care. Where to go for medical services depends on your health care needs. If you are not sure what type of care you need, use the guidelines below or call the member phone number on your health plan ID card. Nurses are available 24 hours a day, seven days a week, and can help you find the care you need.

For routine or primary/preventive care, it is best to go to your own doctor's office. It's important to establish a relationship with a primary care doctor who knows your health history and that you can call when you need care. Some plans may require members to designate a primary care physician and to get referrals before seeing other network providers. For help finding a primary care physician, search our online provider directory or call the member phone number on your health plan ID card.

Another option to consider for non-emergency health conditions is a virtual visit. A virtual visit lets you see and talk to a doctor from your computer or mobile device, without an appointment.[8] Sign in to **myuhc.com** or the UnitedHealthcare app to learn more.

For **hospital care**, work with your physician to determine which hospital is best for your medical/surgical needs. Your benefit plan may require you or your physician to notify us of a hospital admission.

For **care after hours**, first call your primary care doctor. Network doctors and clinics provide either an answering service or a detailed voice-mail message with instructions for how to get care after hours.

Is it urgent? If you need care quickly—but it's not an emergency—and your primary doctor is not available, consider going to an urgent care center. A visit to urgent care typically costs less than going to a hospital emergency room. Urgent care centers offer treatment for non-life threatening injuries or illnesses such as:

- Sprains and strains
- Minor infections
- Sore throats
- Minor broken bones
- Small cuts
- Rashes

[7]For a complete description of the UnitedHealth Premium® designation program, including details on the methodology used, geographic availability, program limitations and medical specialties participating, please visit myuhc.com®.

[8]Virtual Visits and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Data rates may apply.

In an emergency, call 911, or its local equivalent, or go to the nearest emergency room, whether at home or out of town. Typically, an emergency is when injuries or symptoms are life-threatening or severe enough that immediate medical attention is needed. This includes, for example:

- Heavy bleeding
- Sudden change in vision
- Sudden weakness or trouble talking
- Spinal injuries
- Difficulty breathing
- Large open wounds
- Chest pain
- Major burns
- Severe head injuries

Finding care if you are out of town or state

Call the member phone number on your health plan ID card to find doctors and other health care providers near your location, and to learn if any restrictions apply.

For plans that require selection of a Primary Care Physician

Some plans may require members to select a primary care physician (PCP) and get referrals before seeing other network doctors or specialists. A PCP usually specializes in family practice, general practice, internal medicine or pediatrics. Your PCP must be available 24 hours a day, seven days a week or arrange for another physician to be available.

For maximum benefit coverage, all non-emergency services must be provided by or coordinated by your PCP. Depending on your plan type, visits to network doctors other than your PCP—without a referral—may cost you more or may not be covered at all. Check your plan coverage documents for more information on referrals.

If you need urgent care you should contact your PCP, if your PCP cannot accommodate you, ask for approval to visit a participating urgent care center or emergency room (ER). Without PCP approval, your health plan may not pay for the services you received and you may be responsible for the payment.

In the event of a medical emergency where you are unable to call your PCP prior to going to the ER, contact your PCP within 48 hours of receiving treatment to request an authorization for the visit and follow up with your PCP for continuity of care.

Getting and Staying Healthy Health and wellness program

Sign up for **Rally®** on your health plan's member website. It's a program to help you move more and eat better. It even rewards you for your progress.[9]

How it works:

Take your health survey
The health survey will guide you with visual prompts to follow. You'll receive your results as a Rally Age℠ — a number to help you assess how your actual age compares to your health age, based on your survey responses.

Pick your focus
Get personalized activities and recommended missions — or individual action plans — based on your survey results. Missions provide activities to help improve or maintain your health. Choose ones that fit your lifestyle.

[9]Rally provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Earn rewards
As you complete certain activities, you'll earn Rally coins. Use them for chances to win prizes, get discounts, support charities or bid in auctions.

Preventive health guidelines

We encourage our members to receive age and gender appropriate preventive care health services. Routine preventive care helps you manage and maintain your health, and is generally covered at 100% by most health plans when received from a network provider.[10] UnitedHealthcare also covers non-preventive diagnostic services, which may require a copayment, coinsurance or deductible.

Visit **uhc.com/preventivecare** to find age-appropriate preventive care recommendations for everyone covered under your plan. You can print your results and use these recommendations to talk with your doctor about the preventive health screenings that may be right for you.

For specific benefit coverage and limitations, refer to your Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, or call the phone number on your health plan ID card. To get the most out of your benefit coverage, make sure you use a network provider.

Health Management Programs and Services

We have a range of other programs and services to address member health needs along the entire continuum of care. If you are eligible for one or more of the programs or services we will reach out to you. You may access some of these programs online at **myuhc.com**.

These may include:

- Reminder mailings if you are due for, or have missed important services.
- Direct mail brochures and emails related to key preventive care areas.
- Programs to help ensure safe use of narcotic medications and online addiction crisis and support resources.
- Maternity support programs for education and support to help deliver positive pregnancy related outcomes for both mother and the baby.

We also offer a range of Case and Disease Management programs.[11] These programs offer support for dealing with chronic (long-term), complex or critical health conditions. These programs include education and coaching to help address gaps in care around medication and treatment, and encourage healthy lifestyle changes. Our goal is to support your doctor's treatment plan, provide you with self-care techniques and help empower you to manage your health.

Your recent prescriptions, doctor visits, treatments or hospital stays can indicate when one of these programs may benefit you, or your doctor may recommend you to a program. You can also self-refer by calling the member phone number on your health plan ID card to inform us of your program of interest. If eligible, you will receive a letter in the mail or a call from program staff inviting you to participate, and you can choose whether or not to participate. Please log in to your member website for more detailed information about these programs.

[10]Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. UnitedHealthcare also covers other routine services, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

[11]Case and Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. We do not guarantee availability of programs in all service areas and provider participation may vary. Certain items may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated.

Access to behavioral health care

United Behavioral Health (UBH) manages behavioral health benefits, such as mental health and substance use disorder benefits, for many UnitedHealthcare members.[12] If UBH provides your behavioral health benefits, please note the following information.

UBH offers a nationwide network of facilities and clinicians that specialize in the treatment of mental health and substance use problems—including psychiatrists, addiction medicine specialists, psychologists and masters-level clinicians, and advanced practice nurses. UBH also contracts with hospitals, day treatment programs and other specialty care programs.

To request services or get a referral to UBH network facilities and clinicians, call the toll-free Mental Health phone number on your health plan ID card. For routine concerns, call UBH Monday through Friday from 8 a.m. to 5 p.m., within local U.S. time zones, except during holidays. For urgent concerns or to obtain emergency care, UBH Care Advocacy staff can be reached 24 hours a day, including holidays and weekends. In the case of a life-threatening emergency, dial 911, or its local equivalent.

You can also call UBH to determine benefit coverage, learn how to appeal a benefit decision, file a complaint about UBH services or a network clinician or facility, and to get additional information about network clinicians, such as licensure or Board Certification.

To find the names, phone numbers, office locations and clinical specialties of UBH credentialed clinicians, log in to UBH's website, **liveandworkwell.com**. Here you can also:

- Look up your behavioral health benefits
- Find information about mental health conditions, such as depression
- Search for behavioral health clinicians
- Access a variety of assessments and self-help programs
- Submit a claim and view claim status
- Get information in Spanish by selecting Español on the Welcome page

UBH's prevention programs provide information and resources for people with major depression, alcohol and drug use and addiction, and Attention-Deficit/Hyperactivity Disorder. Learn more about these programs by visiting **http://prevention.liveandworkwell.com**.

Call the member phone number on your health plan ID card for questions about:

- Behavioral health benefits, services and notification requirements
- Copayments and other charges for which you may be responsible
- How to get behavioral health services including inpatient and outpatient services, partial hospitalization and subspecialty care
- Getting care when you are away from home
- Submitting a claim for covered service, if applicable
- Information about UBH network practitioners
- Getting care after normal office hours

In addition to the rights and responsibilities outlined in this newsletter, UBH has a rights and responsibilities statement that contains information specific to behavioral health services. Learn more about UBH programs, services and quality improvement programs by reading UBH's annual member newsletter, *liveandworkwell*, at **liveandworkwell.com/newsletter**. To request a paper copy, call the Mental Health phone number on your health plan ID card.

[12]Not all health plans include behavioral health benefits. To find out if your plan includes mental health and/or substance abuse/substance use disorder benefits and the limitations and/or exclusions that may apply, ask your employer, refer to your COC/Member Handbook or call the toll-free member phone number on your health plan ID card.

Other Important Information

Quality improvement programs

We have quality improvement programs that were developed to improve your health care experience. Components of the program include:

- Measuring member and provider satisfaction
- Providing data on key clinical measures to physicians and provider groups to promote evidence-based medical care
- Reporting on and improving our performance on clinical and service measures and measures of customer satisfaction
- Investigating, trending and analyzing quality of care and quality of service complaints
- Promoting public accountability through the accreditation process and reporting to governmental agencies
- Credentialing of our physician and health care professional network

We strive to make improvements in the following areas:

- Quality of care measures, such as rates of cancer screening procedures, and care to children, pregnant women and patients with chronic illnesses such as diabetes
- Member experience measures, such as satisfaction with customer service and the health plan
- Customer service measures, such as hold time or abandonment rate
- Operational measures, such as timeliness in resolving appeals

You may request more information about our quality improvement program by calling us at the toll-free phone number on your health plan ID card.

How to make your health care safer

UnitedHealthcare wants to assist you in finding the safest health care possible. Poor quality can lead to higher complications and surgical repeat rates, unnecessary hospitalizations and a higher chance of wrong diagnosis. That's why UnitedHealthcare develops innovative tools such as the UnitedHealth Premium® designation program. We believe that by supporting and promoting doctors who meet national standards for quality and local benchmarks for cost efficiency, as well as engaging consumers in the health care decision-making process, we can help achieve better health outcomes while improving the experience and reducing costs.[13]

You can find a doctor's Premium designation on myuhc.com. For more information about why choosing a quality doctor and hospital is important, visit **unitedhealthpremium.com.**

We also provide hospital safety information from an organization called The Leapfrog Group®. The Leapfrog Group is a nationally recognized organization of health care purchasers that focus on improvements in patient safety, quality, affordability and transparency of health care. The Leapfrog Group evaluates hospitals based on their self-reported adherence to patient safety and quality measures. For more information about The Leapfrog Group, visit leapfroggroup.org.

[13]The UnitedHealth Premium® program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit myuhc.com for detailed program information and methodologies.

The Leapfrog Group assigns letter grades (A, B, C, D, and F) to hospitals based on their overall performance in keeping patients safe from preventable harm and medical errors. The grades are derived from expert analysis of publicly available data using national evidence-based measures of hospital safety. To find more information or download the free Hospital Safety Score mobile App, visit www.hospitalsafetygrade.org/.

Advance directives

Many people choose to put their health care preferences in writing while they are still able to make such decisions. An advance directive, also known as a "living will," is a document that states the kinds of health care treatment you wish to receive in the event you cannot speak for yourself. A health care proxy is a document that allows you to name a health care agent— someone you trust to make health care decisions for you if you are unable to make or communicate decisions yourself. Both documents should be considered regardless of age or medical condition. Be sure to discuss your advance directives with your physicians, family, friends, health care agent and religious advisors so your wishes are understood. These documents are optional and have no effect on your health coverage.

Women's Health and Cancer Rights Act

As required by the *Women's Health and Cancer Rights Act of 1998*, benefits are provided for mastectomy and for the following covered health services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including copayments, coinsurance and any annual deductible) and the benefit coverage limitations are the same as are required for any other covered health service as described in your Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.[14] However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification (sometimes referred to as preauthorization). For information on precertification, please call us at the toll-free phone number on your health plan ID card.

[14]For members in Colorado, if 48-hours or 96-hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

Why the last weeks of pregnancy count

You may not have a choice about when to have your baby. If there are problems with your pregnancy or your baby's health, you may need to deliver your baby early. But if you have no medical problems and you're planning to schedule your baby's birth, you should wait until the thirty-ninth completed week of your pregnancy. Births scheduled before the thirty-ninth completed week of pregnancy for non-medical reasons can cause problems for both mothers and babies. For babies, this time is also vital in the development of their brain and lungs.

For more information about why the last few weeks of pregnancy are so important to you and your baby, along with additional resources and tools, visit our Health Library at **https://healthlibrary.uhc.com/content/healthlibrary/uhc/hl/womens-health/healthy_pregnancy/resources.html**. To find information on how often your hospital schedules early cesarean sections and inductions as reported in The Leapfrog Group annual hospital survey statistics, visit http://www.leapfroggroup.org/ratings-reports/maternity-care.

Evaluation of new medical technologies

UnitedHealthcare's Medical Technology Assessment Committee evaluates the strength of clinical evidence supporting the use of new and existing health services. Conclusions of this Committee help to determine whether new medical technology and health services will be covered. The Medical Technology Assessment Committee is comprised of medical directors with diverse specialties and subspecialties from throughout UnitedHealth Group and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealth Group. The Committee meets at least 10 times a year to review published clinical evidence, information from government regulatory agencies and nationally accepted clinical position statements regarding new and existing medical technologies and treatments, to assist UnitedHealthcare in making informed coverage decisions.

Financial incentives

We want you to know that the staff, physicians and other health care professionals who make decisions on the health care services you receive do so based on the contract your employer has with UnitedHealthcare.

- The decisions are made based on the appropriateness of care and service, and existence of coverage.
- The staff of UnitedHealthcare, its delegates, and the physicians and other health care professionals making these decisions are not specifically rewarded for issuing noncoverage decisions.
- UnitedHealthcare and its delegates do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services.

Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by our personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how we protect your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.

- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an advance directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your member ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to **myuhc.com**, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to **myuhc.com**, or call us before receiving services, to verify that your doctor or health care professional participates in the UnitedHealthcare network.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

Medical Information Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as **www.myuhc.com** or **www.oxfordhealth.com.** We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

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[1]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD –Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice, go to www.uhc.com/privacy/entities-fn-v1.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment**. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations**. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health, or we may analyze data to determine how we can improve our services. We may also deidentify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products**, such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities,** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings**, such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions,** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes,** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.

- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of certain health information we maintain about you, such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you, such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your plan website, such as **www.myuhc.com** or **www.oxfordhealth.com.**

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-633-2446 (TTY 711).**

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare
  Customer Service -Privacy Unit
  PO Box 740815
  Atlanta, GA 30374-0815

- Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

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[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health, LLC, OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC,; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC and UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice, go to www.uhc.com/privacy/entities-fn-v1.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About This Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 (TTY 711).**

State-Specific Notices

The following pages include state-specific notices for members of those plans. Information in these notices is current as of the date of issue and may be subject to change at any time due to employer-directed plan changes, state mandates and federal laws. Please refer to your COC/Member Handbook for specific information on your benefits or refer to your member website for the most up-to-date information.

California

Important Notice to Subscribers of UnitedHealthcare Benefits of California

Appealing a Health Care Decision

How to Dispute a Determination

If do not agree with a benefit determination, you have the right to appeal the decision by filing a grievance with your health plan. You may submit your grievance within 180 days from the service date. You or someone you designate (your authorized representative) may submit your grievance verbally or in writing. You can call your health plan at the numbers listed below to learn how to name your authorized representative.

The person who reviews your grievance will not be the person or a subordinate of that person, who made the original decision.

There are two types of grievances: Standard and Expedited

Standard Grievance Process

A standard grievance will be resolved within 30 days. To file a grievance, submit a copy of your denial notice and a brief explanation of your situation, and any other relevant information to the address listed below, or call:

UnitedHealthcare Benefits Plan of California
Attention: Member Appeal Dept.
P.O. Box 30573
Salt Lake City, UT 84130-0573
1-800-260-2773
TTY: Dial 711
www.myuhc.com
Standard Fax: 1-801-938-2100

Expedited/72 hour Grievance Process

Your health plan makes every effort to resolve your grievance as quickly as possible. In some cases, you have the right to an expedited grievance when a delay in the decision making might pose an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, major bodily function, or the normal timeframe for the decision making process would be detrimental to your life, or health or could jeopardize your ability to regain maximum function. If you request an expedited grievance, your health plan will evaluate your grievance and health condition to determine if your grievance qualifies as expedited. If so, your grievance will be resolved within 72 hours. If not, your grievance will be resolved within the standard 30 days.

You or someone you designate may submit your expedited grievance verbally or in writing. Specifically state that you want an expedited grievance or that you believe your health might be seriously jeopardized by waiting for the standard grievance process.

Your health plan will make a decision on your expedited grievance and will notify you in writing of the decision within 72 hours of receiving your grievance.

For an Expedited Grievance:

- **Call: UnitedHealthcare Benefits Plan of California Customer Service at 1-800-260-2773 or TTY/TDD 711.** UnitedHealthcare Benefits Plan of California will document and process your grievance.
- **Write:** UnitedHealthcare Benefits Plan of California
  Attention: Expedited Member Appeals
  P.O. Box 30573
  Salt Lake City, UT 84130-0573
  Expedited Fax: 1-801- 994-1083

Simultaneous Appeal

For urgent or immediate concerns, you may file a grievance at the same time with both the health plan and the Department of Managed Health Care. The instructions above tell you how to file an expedited grievance with the plan. The instructions below tell you how to file a grievance with the Department.

Department of Managed Health Care Complaint Process

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **UnitedHealthcare Benefits Plan of California at 1-800-260-2773 and the hearing and speech impaired may call TTY/TDD 711**, and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Availability of Consumer Assistance Services

There may be other resources available to help you understand the grievance process. For questions about your rights, this notice, or for assistance, you can contact the consumer assistance program at:

California Consumer Assistance Program
Operated by the California Department of Managed Health Care
980 9th St, Suite #500
Sacramento, CA 95814
Toll free telephone: (888) 466-2219
TDD: 1-877-688-9891
http://www.HealthHelp.ca.gov
E-mail: Helpline@dmhc.ca.gov

If you have questions about this notice, please call us at 1-800-260-2773 or TTY/TDD 711.

Important Notice to Subscribers of UnitedHealthcare Insurance Company in California

Claim Disputes

Should a dispute concerning a claim arise, contact us first. If the dispute is not resolved contact the California Department of Insurance at www.insurance.ca.gov.

Call us at the phone number shown on your ID card.

Call the California Department of Insurance at:

- 1-800-927-HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

A Covered Person may write the California Department of Insurance at:

California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

For further information about complaint procedures please read the section below.

Timely Access to Care

Covered health care services are provided and arranged in a timely manner, as appropriate for the nature of condition, as consistent with good professional practice and meet the California standards regarding access to care.

For Medical Services, appointment wait times are as follows:

- Emergency health services are available and accessible within the plan's service area 24 hours, 7 days a week. Ambulance services for the service area served by the plan for transportation to the nearest 24-hour facility with physician coverage.
- Urgent health care services that do not require prior authorization are offered within 48 hours of the request. Urgent health care services that require prior authorization are offered within 96 hours of the request.
- Non-urgent care primary care and non-urgent, non-physician mental health services are offered within 10 business days of the request.
- Non-urgent specialist care and ancillary services (i.e. vision care services) are offered within 15 business days of the request.

For Dental Services, providers in our network are required to have appointment availability within specified time frames:

- Emergency services: 24 hours
- Urgent appointments: within 72 hours of the time of request for appointment
- Non-urgent and preventive dental care appointments: within 14 business days

Telephone Triage/Nurse Lines

- Telephone triage or screening services are provided in a timely manner appropriate for the insured's condition. During normal business hours, the waiting time for a plan member to speak by telephone with a customer service representative knowledgeable and competent regarding the plan member's questions and concerns will not exceed ten minutes.

Language Assistance

Interpreter services will be coordinated with scheduled appointments for covered health services in a manner that ensures interpreter services will be available at the time of the appointment.

Network Provider Accessibility Complaints

If you have a complaint regarding your ability to access Covered Health Services from a Network provider in a timely manner, call us at the telephone number shown on your ID card. If you would rather send your complaint to us in writing, the customer care representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance.

Call the California Department of Insurance at:

- 1-800-927-HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

You may write the California Department of Insurance at:
California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Colorado

Important Notice to UnitedHealthcare of Colorado, Inc. Subscribers

Operations

Under the terms of a management agreement between UnitedHealthcare of Colorado, Inc. and United HealthCare Services, Inc., United HealthCare Services provides all management, occupancy and administrative services for UnitedHealthcare of Colorado. United HealthCare Services and UnitedHealth Group Incorporated, the ultimate parent company of UnitedHealthcare of Colorado, are located in Minnesota. Accounting records are maintained in the corporate office in Minnetonka, Minnesota. UnitedHealthcare of Colorado operates a mixed model HMO that provides health care benefits to employer groups. The company contracts with independent professional physicians, hospitals, and other health care providers to provide access to health care to its members. UnitedHealthcare of Colorado pays physicians a negotiated fee for services rendered by these providers.

Organizational Structure

UnitedHealthcare of Colorado, Inc. is a wholly owned subsidiary of UnitedHealthcare, Inc., which is wholly owned by United HealthCare Services, Inc., a wholly owned subsidiary of UnitedHealth Group Incorporated.

UnitedHealthcare of Colorado, Inc. Financial Information as of December 31, 2018

Balance Sheet:
Assets: $43,119,858
Liabilities: $27,690,772
Net Worth: $15,429,086
Total Net Worth/Liabilities: $43,119,858

Income Statement:
Revenue: $92,275,672
Medical Expenses: $69,823,710
Administration: $18,876,345
Total Expenses: $86,795,055
Provisions for Income Tax: $1,202,449
Income: $4,851,746

Quick Reference Guide

If you need:

- To find a participating physician
- Benefit information
- To inquire about a bill you received
- A new health plan ID card
- A provider directory
- To file a complaint or appeal
- Information regarding how your plan works
- Information regarding how your claim was paid
- A copy of your appeal rights
- Prior authorization for Mental Health services
- To find a participating Mental Health provider
- Information regarding how your Mental Health Claim was paid
- Pharmacy benefit information
- A Mail Order Prescription form
- Mail Order Pharmacy Customer Service

Please call:
The member phone number on your health plan ID card or log in to myuhc.com

Network Access
UnitedHealthcare has prepared and maintains a network access that describes how the plan monitors the network of providers to ensure that you have access to network providers. The access also has information on the referral processes, compliant procedures, quality programs and emergency services coverage provisions. The network access plan is available at the plan's office: 6465 Greenwood Plaza Blvd, Suite 300, Centennial, CO, 80111, or call 1-800-842-4509.

Surprise Bills
Beginning January 1, 2020, Colorado state law protects you from "surprise billing", also known as "balance billing", when you receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado. The law also protects you when you unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado. Additional information can be found at uhc.com/legal/required-state-notices/colorado.

Immunization Records
Immunization records may be disclosed to a public health authority for the purpose of preventing or controlling disease and public health interventions. The Colorado Department of Public Health and Environment is a public health authority and is authorized by the Colorado Immunization Registry Act (Section 25-4-2403, C.R.S.) to collect and receive immunization information for the purpose of preventing or controlling disease and public health interventions. The Colorado Immunization Information System (CIIS) is a computerized immunization tracking system operated by the Colorado Department of Public Health and Environment.

You can choose at any time to have your/your child's shots excluded from the CIIS. You need to complete a form available from your healthcare provider or the CIIS website at https://www.colorado.gov/pacific/cdphe/ciis-opt-out-procedures.

Connecticut

Important Notice to Connecticut Plan Subscribers

Health Care Services from Out-of-Network Providers

For plans that contain Network and Out-of-Network benefits:
If you are diagnosed with a condition or disease that requires specialty care and either we do not have a Network provider with the required specialty training or if access to a Network provider would require unreasonable travel or delay, you may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network providers. In this situation, you may contact us at the telephone number on your ID card, or your Network provider can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network provider to coordinate care through an Out-of-Network provider. If your care is coordinated through an Out-of-Network provider, Covered Health Care Services will be paid as Network Benefits.

For plans that only contain Network benefits:
If you are diagnosed with a condition or disease that requires specialty care and either we do not have a Network provider with the required specialty training or if access to a Network provider would require unreasonable travel or delay, you may be eligible for Benefits when Covered Health Care Services are received from Out-of-Network providers. In this situation, you may contact us at the telephone number on your ID card or your Network provider can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network provider to coordinate care through an Out-of-Network provider.

Florida

Important Notice to Neighborhood Health Partnership, Inc. and UnitedHealthcare Members in Florida

Upon completion of UnitedHealthcare's internal grievance process or at any time during a grievance process, if you are not satisfied with the resolution, you may file a grievance with the Florida Agency for Health Care Administration by writing or calling them at:

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456

At any time during the the grievance process, you may also contact the Agency for Health Care Administration about quality of care issues.

For more information about your external grievance and appeals rights, please refer to your COC/Member Handbook.

Grievance Filings
In accordance with Section 641.511 of the Florida Statutes and Rule 69O-191.078(10) of the Florida Administrative Code, we have updated relevant medical policies to ensure that all concerned subscribers have the mandated statutory timeframe of one year from the date of occurrence within which such subscribers can file a formal grievance as applicable. This applies to medical policies offered by UnitedHealthcare of Florida, Inc. and Neighborhood Health Partnership, Inc.

Hawaii

Important Notice to UnitedHealthcare Members in Hawaii

Orthodontic Services for Treatment of Orofacial Anomalies

Benefits are provided for Medically Necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes for Covered Persons under the age of 26. "Orofacial anomalies" means cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration. "Orthodontic services" means direct or consultative services provided by a licensed dentist with a certification in orthodontics by the American Board of Orthodontics. "Treatment of orofacial anomalies" includes the care prescribed, provided, or ordered for an individual diagnosed with an orofacial anomaly by a craniofacial team that includes a licensed dentist, orthodontist, oral surgeon, and Physician, and is coordinated between specialists and providers.

Illinois

Important Notice to Illinois Subscribers of UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare Insurance Company of the River Valley, UnitedHealthcare of Illinois, Inc. and UnitedHealthcare Plan of the River Valley, Inc.

Dependent Coverage

As part of the federal Patient Protection and Affordable Care Act (more commonly known as Health Care Reform), dependents under the age of 26—regardless of marital status—may be eligible for coverage under your employer sponsored health plan (medical, vision and/or dental benefits), if dependent coverage is offered.

In addition, under Illinois law, any unmarried dependent child under 30 years of age is eligible for dependent coverage if the dependent meets all three (3) of the following conditions:

(i) is an Illinois resident,
(ii) served as an active or reserve member of any U.S. Armed Forces and
(iii) received release or discharge other than dishonorable discharge.

Enrollees must submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service. Please note your employer may require you to pay for all or part of the cost of your dependent's health care coverage.

To find out if your plan offers dependent coverage, check your benefit plan documents or contact your employer's benefit representative. For information regarding specific benefit coverage, log in to myuhc.com® or call the member phone number listed on your health plan ID card.

Your Right to Select a Woman's Principal Health Care Provider

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a primary care physician. A woman's principal health care provider is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. A woman's principal health care provider may be seen for care without referrals from your primary care physician. If you have not already selected a woman's principal health care provider, you may do so now or at any other time. You are not required to have or to select a woman's principal health care provider. Your woman's principal health care provider must be a part of your plan. You may get the list of participating obstetricians, gynecologists, and family practice specialists from your employer's employee benefits coordinator. You may also select a women's principal health care provider from the online physician directory located on myuhc.com, or for your own copy of the current list, you may call the member phone number on your health plan ID card. The list will be sent to you within 10 days after your call. To designate a woman's principal health care provider from the list, call the member phone number on your health plan ID card and tell our staff the name of the physician you have selected.

You have the right to request an updated list of participating health care providers. You can request this information by calling the member phone number on your health plan ID card. To view an updated list of participating health care providers, log in to myuhc.com and click on Find a Doctor.

Your Heart Health

Heart disease is the No.1 killer of all Americans, but a healthy diet and lifestyle can help reduce your risk of getting heart disease. The American Heart Association® has identified seven factors that can impact your health and your quality of life:

"Life's Simple 7"

- Don't smoke
- Maintain a healthy weight
- Engage in regular physical activity
- Eat a healthy diet
- Manage blood pressure if abnormal
- Control your cholesterol levels
- Keep your blood sugar (glucose) at healthy levels

Smokers have a higher risk of death from coronary heart disease and stroke than nonsmokers. Quitting smoking is an important part of preventing a future heart attack or stroke. In addition to exercising regularly and eating healthy, have your cholesterol and blood pressure checked annually and follow your doctor's instructions for managing normal levels.

Even simple, small changes can help make a big difference in maintaining your cardiovascular health, reducing your health care costs and living a potentially longer life.

Kentucky

Important Notice to UnitedHealthcare of Kentucky, Ltd. Subscribers; Subscribers under UnitedHealthcare Insurance Company Policies Issued to Employer Groups Located in Kentucky; and Subscribers in Northern Kentucky Covered under UnitedHealthcare of Ohio, Inc.

Your Appeal Rights Under Kentucky State Law:

For specific information on the timelines and appeal rights under Kentucky State law, please refer to your COC. Your COC will contain prevailing information concerning your specific situation.

Availability of Financial Statement:

A copy of the most recent annual financial statement and organizational structure of UnitedHealthCare of Kentucky, Ltd., UnitedHealthcare Insurance Company and UnitedHealthcare of Ohio, Inc. is available for review at the servicing UnitedHealthcare office during normal business hours. To request to see a copy, please call the member phone number on your health plan ID card.

Louisiana

Important Notice to UnitedHealthcare of Louisiana, Inc. Subscribers; Subscribers under UnitedHealthcare Insurance Company Policies Issued to Employer Groups Located in Louisiana; and UnitedHealthcare Affiliate Plan Subscribers Residing in Louisiana.

Louisiana Balance Billing Disclosure Member Notice

Health care services may be provided to you at network health care facilities by facility-based physicians who are not in your health plan network. You may be responsible for payment of all or part of these fees for those non-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services.

Specific information about network and non-network facility-based physicians can be found at myuhc.com®, or by calling the toll-free member telephone number on your health plan ID card.

Maine

Important Notice for Maine Plan Subscribers and Residents

Coverage for Reconstructive Surgery after Mastectomy

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Benefits include medically appropriate inpatient coverage following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer including breast reconstruction procedures for the period of time determined by the attending Physician in consultation with the Covered Person.

Comparable Health Care Services Incentive program

As of January 1, 2019, all carriers in Maine are required to offer small groups with a Health Savings Account (HSA) plan an incentive program for enrollees to shop for low-cost, high quality participating providers for comparable health care services. Please refer to your plan documents for a detailed description and to determine if you are eligible to participate in the Comparable Health Care Services Incentive program.

Massachusetts

Important Notice to UnitedHealthcare Members in Massachusetts

Your Rights Under Mental Health Parity Laws

This plan is subject to state and federal Mental Health Parity laws, which generally prohibit insurance plans from providing mental health or substance use disorder benefits in a more restrictive manner than other medical benefits. If a health plan member believes UnitedHealthcare standards or practices relating to the provision of mental health or substance use disorder benefits are not compliant with applicable mental health parity laws, the health plan member or an authorized representative may submit a complaint to the Division of Insurance at:

Division of Insurance
1000 Washington Street, Suite 810 Boston, MA 02118-6200
Telephone: 1-877-563-4467
Fax: 1-617-521-7794
TTD/TDD: 1-617-521-7490

Complaints may be submitted verbally or in writing to the Division's Consumer Services Section for review. Insurance Complaint Forms can be found on the Division's webpage at: http://www.mass.gov/ocabr/insurance/consumer-safety/file-a-complaint/. Submitting a complaint to the Division does not impact your internal or external appeal rights under this plan.

Gender Discrimination Notice

Massachusetts law prohibits discriminating against an individual because of his/her gender identity or expression. This prohibition extends to the availability of health insurance coverage as well as to the provision of health insurance benefits. Therefore, the denial of coverage for medically necessary treatment based on an individual's gender identity or gender dysphoria is sex discrimination and is prohibited under Massachusetts law.

How To Obtain a Binding Estimate

Massachusetts law allows insured members of Massachusetts based health insurance plans to contact their health insurance carriers to request a binding estimate of the cost of certain health care services. If you desire such an estimate, contact Consumer Services at the number on the back of your ID card. The amount you will be provided is only an estimate and it is good for 90 days. The cost of a service can change based on your medical condition at the time of the service and could be affected by services being performed that were not part of the original estimate. Specific cost estimates are not available pre-service for anesthesia or facility charges. You could be responsible for payment of services your health plan does not cover. The true payment and charges will be determined when the claim is filed. Please note that the cost estimator tool on **myuhc.com** is not intended to be, and should not be relied upon, for obtaining the binding cost estimate that Massachusetts law allows insured members to request.

Radiologic Imaging Service

Certain radiologic imaging service (such as CT scans, MRI and MRA), when performed in a hospital outpatient location, may not be considered "medically necessary." There are some exceptions to this, but if you receive a letter that says your radiologic imaging service will not be covered because it will be performed in a hospital outpatient location and that site of care is not medically necessary, you can do the following to find a covered free standing location to perform the radiologic imaging service:

1. Log in at **myuhc.com** and click on Find a Care & Costs. Next, click on the Medical Directory>Places>Labs & Imaging>Imaging Centers. Refine your results by adjusting the location, distance, and type of specialty needed for your care.

2. Or, call the toll-free member number on your health plan ID card Monday through Friday, 8 a.m. to 8 p.m. local time. TTY users dial 711.

You may also be contacted by email, phone call or text, to inform you that the service will not be covered unless you select a free-standing imaging center. The outreach will direct you to a website or customer service where we will help you find a covered location and schedule a new appointment.

Mid-Atlantic States

Important Notice to UnitedHealthcare of Mid-Atlantic, Inc., MD-Individual Practice Association, Inc. and Optimum Choice, Inc. Subscribers (DE, MD, VA and WV)

UnitedHealthcare of Mid-Atlantic, Inc.

1. Included below is a summary of the most recent financial report that UnitedHealthcare of Mid-Atlantic, Inc. (UHCMA) has submitted to the Insurance Commissioner:

   Statutory Financial Report for UnitedHealthcare of Mid-Atlantic, Inc. for the Twelve Months Ended December 31, 2018

   - Revenue $980,774,442
   - Medical Service Expenses $767,378,075
   - Gross Margin $213,396,367
   - Administrative Expenses $153,283,854
   - Investment and Other $4,940,062
   - Net Income Before Taxes $64,483,575
   - Income Tax Incurred (Benefit) $17,328,704
   - Net Income $47,154,871

2. If you have questions about the accessibility and availability of services, including where and how to obtain them, please call the member phone number on your health plan ID card.

3. If you do not access services through network providers or hospitals, please be aware that benefits are subject to deductibles and lower levels of reimbursements.

4. Maryland law requires Health Maintenance Organizations to notify members of the procedures for obtaining emergency services. Please refer to the section titled: “Obtaining routine or primary care, urgent care or emergency care. If you have any questions or concerns about how any of these laws affect you and your health benefit plan, please call the member phone number on your health plan ID card.

5. 94.5% of UHCMA Maryland membership is enrolled in our Medicaid product and is assisted by public funds.

6. UHCMA is subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1. If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman at: Office of the Managed Care Ombudsman, Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218; toll-free phone: 1-877-310-6560, select option 1; fax: 804-371-9944; or email: ombudsman@scc.virginia.gov.

7. UHCMA provides health care services to its members statewide in Virginia.

8. 7% of UHCMA Virginia membership is enrolled in our Medicaid product and is assisted by public funds.

For complete details about your coverage, including exclusions and limitations, please refer to your COC. Please always review this document before accessing care in order to ensure that the services you are seeking are covered by your benefit plan. Finally, if you are ever in doubt as to whether 1) your provider or a provider that you have been referred to is a participating provider, 2) your benefit plan covers a particular service, 3) a referral must first be obtained or UHCMA must be notified — or if you have any other questions regarding your health care coverage — please call the member phone number on your health plan ID card.

Optimum Choice, Inc. and MD- Individual Practice Association, Inc.

1. Included below is a summary of the most recent financial report that Optimum Choice, Inc. and MD-Individual Practice Association, Inc. have submitted to the Maryland Insurance Commissioner:

   Statutory Financial Report for Optimum Choice, Inc. for the Twelve Months Ended December 31, 2018

Revenue	$274,772,413
Medical Expenses	$198,847,373
Gross Margin	$75,925,040
Administrative Expenses	$47,869,807
Investment and Other	$2,283,081
Income Before Taxes	$30,338,314
Income Tax	$6,769,255
Net Income	$23,569,059

   Statutory Financial Report for MD - Individual Practice Association, Inc. for the Twelve Months Ended December 31, 2018

Revenue	$281,800,483
Medical Expenses	$228,360,092
Gross Margin	$53,440,391
Administrative Expenses	$21,261,101
Investment and Other	$766,267
Income Before Taxes	$32,945,557
Income Tax	$8,167,766
Net Income	$24,777,791

2. Currently we do not offer any individual products.

3. If you have questions about the accessibility and availability of services, including where and how to obtain them, please call the member phone number on your health plan ID card.

4. If you do not access services through network providers or hospitals, please be aware that benefits are subject to deductibles and lower levels of reimbursements.

5. Maryland law requires Health Maintenance Organizations to notify members of the procedures for obtaining emergency services. Please refer to the section titled: “Obtaining routine or primary care, urgent care or emergency care. If you have any questions or concerns about how any of these laws affect you and your health benefit plan, please call the member phone number on your health plan ID card.

6. Optimum Choice, Inc. and MD-Individual Practice Association, Inc. are subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

7. Optimum Choice, Inc. and MD-Individual Practice Association, Inc. provide health care services to its members statewide.

NOTICE FOR DELAWARE SUBSCRIBERS:

Delaware law requires notice of certain mandatory benefits provided by your contract with UnitedHealthcare. Coverage must include:

- Coverage for dependents, as defined by state law, until the dependent’s twenty-sixth birthday.
- For plans that provide coverage for other prosthesis, coverage shall include scalp hair prosthesis worn for hair loss suffered as the result of alopecia areata, resulting from an autoimmune disease.

- For plans that provide coverage for medical and surgical benefits with respect to a mastectomy, coverage shall include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas.

Please refer to your Certificate of Coverage for specific information on your covered benefits. Benefits may require pre-authorization or may be subject to other conditions or limitations as allowed by state law.

NOTICE FOR MARYLAND SUBSCRIBERS:

Maryland law requires notice of certain mandatory benefits provided by your contract with UnitedHealthcare. Coverage must include:

- Inpatient hospitalization for a mother and newborn child for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section. If a covered mother and her newborn child are discharged before the 48 or 96 hours has expired, the plan will provide for one (1) home visit scheduled to occur within twenty-four (24) hours after the hospital discharge; and an additional home visit, if prescribed by the attending provider. For a covered mother and her newborn child who remain in the hospital for at least the length of time of 48 or 96 hours, we will provide coverage for a home visit, if prescribed by the attending physician.

- Inpatient care for a minimum forty-eight (48) hour hospital stay after a mastectomy or the surgical removal of a testicle. The patient is allowed to request a shorter length of stay if, in consultation with the attending physician, less time is determined to be needed for recovery. For a patient who receives less than forty-eight (48) hours of inpatient hospitalization, or who undergoes a mastectomy or surgical removal of a testicle on an outpatient basis, the plan will provide for one (1) home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility and an additional home visit, if prescribed by a physician. For a patient who remains in the hospital for at least the length of 48 hours, we will provide coverage for a home visit, if prescribed by the attending physician.

- Habilitative services for Insured and Enrollees who are children until at least the end of the month in which the insured or enrollee turns 19 years old, except for habilitative services and devices provided in early intervention and school services. "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living. The limits for physical, speech and occupational therapy do not apply to the visits received in connection with this Benefit.

Please refer to your Certificate of Coverage for specific information on your covered benefits. Benefits may require pre-authorization or may be subject to other conditions or limitations as allowed by state law.

Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance

For full mental health benefit information please refer to your Certificate of Coverage (COC) and Schedule of Benefits, or contact UnitedHealthcare at the number on your health plan ID card. In addition, you may refer to the Maryland Insurance Administration website:
www.insurance.maryland.gov.

Maryland Proposed Rate Increase Information Notice

Maryland law, S.B. 769, requires insurance carriers, such as UnitedHealthcare, to provide Individual plan and Small Group members with direction on where to access proposed rate increase information and submit comments regarding those proposed rate increases.

You can view the proposed health plan rate increase information and submit comments regarding the proposed rate changes to the Maryland Insurance Administration on their website at: http://www.healthrates.mdinsurance.state.md.us/.

For all other Maryland insurance information, please access the following link to the Maryland Insurance Administration website: www.insurance.maryland.gov.

Physician Compensation Disclosure

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment methods such as fee-for-service payments, salary, or capitation. The Maryland Physician Compensation Disclosure can be accessed at https://www.uhc.com/legal/required-state-notices/maryland.

Claims Submissions

You may submit claims forms by first-class mail or by fax. Medical claims:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Fax: 248-733-6000

If you use our network of providers, you should not have to submit a claim. If you do need to submit a claim, claim forms can be found on myuhc.com.

NOTICE FOR VIRGINIA SUBSCRIBERS:

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, please call the member phone number on your health plan ID card.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218-1157; 804-371-9691 or toll-free at 1-877- 310-6560; or bureauofInsurance@scc.virginia.gov.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available. We recommend that you familiarize yourself with our grievance procedure and make use of it before taking any other action.

NOTICE FOR WEST VIRGINIA SUBSCRIBERS:

West Virginia law requires notice of certain mandatory benefits provided by your contract with UnitedHealthcare. Coverage must include:

- Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists.
- A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen or over.
- A test for the human papilloma virus (HPV) for women age eighteen or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen and over.
- Rehabilitation services, which includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status.
- Child immunization services, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration.

- Emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition.
- Colorectal cancer screening for a nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy.
- Any covered person diagnosed with diabetes has the right to direct access to an eye care provider of their choice from the insurer's panel of providers for an annual diabetic retinal examination.
- A female enrollee has the right to direct access to a women's health care provider of her choice for a well woman examination.
- Reconstruction of the breast following mastectomy; or reconstructive or cosmetic surgery required as a result of an injury caused by an act of family violence as defined by state law, when the person inflicting the injury was convicted of a felony, a lesser included misdemeanor offense, or a charge of domestic battery for inflicting the injury.

Please refer to your Certificate of Coverage for specific information on your covered benefits. Benefits may require pre-authorization or may be subject to other conditions or limitations as allowed by state law.

New Hampshire

Important Notice for New Hampshire Plan Subscribers and Residents

Continuation of Coverage Rights

If your coverage ends under the policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or New Hampshire state law. For further information about your federal and state continuation of coverage rights, please refer to your Certificate of Coverage. For a detailed summary of your current continuation of coverage rights under New Hampshire law, visit http://www.uhc.com/legal/requiredstatenotices/new-hampshire.

Out-of-Network Services

Carriers are required under RSA 420-J:7 to maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

If you need covered health care services that are not available from a network provider—or access to a network provider would require unreasonable delay or travel—you, your doctor or a representative acting on your behalf can ask for an exception (also known as a referral) to an out-of-network provider. If you, or your provider, do not contact us to get an exception/referral prior to services being rendered by a non-network provider, covered services will be reimbursed at the out-of-network benefit level.

For help finding a network provider, or to request an exception/referral to an out-of- network provider, contact us at 1-800-357-0978. For mental health and substance use disorder services, call us at 1-800-842-2065.

Some plans provide benefit coverage for care received outside the network. Check your plan coverage before selecting a physician or hospital. For plans that include out-of-network coverage, in addition to your cost share, you may be required to pay any difference between the covered amount and the amount charged by the out-of-network provider.

You have the right to appeal a decision. Internal grievance and external review for medical necessity determination procedures are outlined in the Policyholder's Certificate.

New Jersey

Important Notice to UnitedHealthcare Subscribers in New Jersey

Independent Consumer Satisfaction Survey results

If you would like to request the New Jersey Independent Consumer Satisfaction Survey results and an analysis of quality outcomes of health care services of managed care plans on the State, contact:

Office of Health Care Quality Assessment
New Jersey Department of Health
P.O. Box 360
Trenton, NJ 08625-0360
1-800-418-1397

Managed Health Care Consumer Assistance Program

This program was created as a means to assist consumers in better understanding the current status of the health insurance market and particularly managed care. The toll-free number for the Managed Health Care Consumer Assistance Program is 1-800-446-7467.

Standards for Access to Service

We recognize that timely access to medical services is important whether you need a physical, a mammogram or an appointment to be treated for an unexpected illness. That's why we've developed provider service standards and regularly monitor our physician and provider network for compliance with these standards. As a UnitedHealthcare member, you can expect to see a physician for urgent care the same day, routine symptomatic care (non-urgent, but in need of attention) within 14 days or a regular physical exam within 4 weeks.

Organ Donation

Organ, eye and tissue donation gives people a second chance at life. To learn more about the benefits of organ and tissue donation and transplantation, or register to be a donor, visit https://www.njsharingnetwork.org/.

Member Rights and Responsibilities

As a Member you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status and function of any personnel delivering Covered Services to you.

   You also have the right to receive all information from a Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

   Finally, you have the right to refuse treatment to the extent permitted by law. We and your Network Provider will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and We and your Network Provider believe no professionally acceptable alternative exists, We will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

   If a Member is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee or a family member.

2. The right to be provided with information about Our services, policies, procedures, grievance and appeal procedures and Our Network Providers that accurately provides relevant information in a manner that is easily understood. This means you have a right to and will be provided with: a Certificate (includes Member Handbook), a Summary of Benefits, any applicable riders and a Provider Directory. Upon request, you may receive a listing of Our Network Providers who accept Members who do not speak English.

3. You have the right to be informed of changes in benefits, services or Our Provider Network on a timely basis.

4. The right to select a Primary Care Physician (PCP), as described in the policy Certificate and the Provider Directory. For In-Network coverage, you have the right to your choice of specialists from among Our Network Specialists, subject to availability and the terms and conditions of the policy Certificate. When Medically Necessary, you have the right to a Standing Referral to a Network Specialist for the treatment of a chronic condition as described in the policy Certificate.

5. The right to quality health care services, provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decisionmaking regarding your health care.

6. You have the right to formulate an Advance Directive.

7. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.

8. The right to initiate disenrollment from the Plan.

9. The right to file a formal grievance or appeal if complaints or concerns arise about Our medical or administrative services or policies. You also have the right to file a complaint with the New Jersey Department of Banking and Insurance and to receive an answer to those complaints within a reasonable period of time.

10. You have, when Medically Necessary, the right to medical services without unnecessary delay. This includes Emergency Care and Urgent Care 24 hours a day, seven days a week.

11. You have the right to be advised if any of the Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.

12. Regarding In-Network Covered Services under the policy Certificate, you have the right to be free from “balance billing” by Our Network Providers. However, you are responsible for any applicable Copayments, Coinsurance, and Deductibles.

13. The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your provider.

New Jersey and New York

Important notice to New Jersey and New York Subscribers of UnitedHealthcare and UnitedHealthcare Insurance Company of New York, Inc.

Overview of Provider Reimbursement Methodologies

Generally, UnitedHealthcare pays Network Providers on a fee-for-service basis. Fee-for-service based payment schedules differ depending on the type of provider, geographic location, or site of service, and may include payment based on each office visit, a hospital day, procedure or service performed, item furnished, course of treatment, or other units of service. A unit of service, such as a hospital day, may include more than a single procedure or item. We may also limit the number of services or procedures that we will pay for during any single office visit or for any single procedure; or for multiple procedures performed at the same time. This practice is known as "bundling" and is used by many third party payers, including the Medicare program. Some providers have agreed to accept variable fee for service payments, payment based on a mutually agreed upon budget, so long as they receive at least a minimum fee. UnitedHealthcare may make modifications to its fee for service compensation mechanism during the term of your coverage.

UnitedHealthcare does not typically "withhold" a portion of a physician's contracted fees, which might be paid later depending on the physician's performance or financial performance of UnitedHealthcare. (The amount retained is called a "Withhold.") However, Withholds are among the sanctions that UnitedHealthcare may implement with respect to physicians who have a demonstrated practice of not following UnitedHealthcare policies, for example, by improper billing practices, consistently referring members to providers who are not Network Providers or by failing to obtain required referrals or Precertifications. UnitedHealthcare may profile Network Providers' billing, referral, utilization, or other practices, and develop other financial disincentives for providers who do not follow UnitedHealthcare policies and procedures during the term of your coverage.

UnitedHealthcare does not generally provide Bonuses or other Incentives to Network Providers. However, UnitedHealthcare has entered into Incentive Agreements with a few "intermediaries," such as provider groups and independent practice associations (IPAs). Incentive Agreements may be based on, referrals to specialists or hospitals and other facilities, economic factors, quality factors, member satisfaction factors, or a combination of these and other factors. Incentive Agreements typically, but not always, require the group to meet mutually agreed upon quality measures as a condition of obtaining a Bonus based on cost or utilization. Financial incentives or disincentives may also be adopted to promote electronic billing practices or other e-commerce initiatives, or to promote compliance with UnitedHealthcare utilization management policies. In addition, physicians may be paid at higher rates for certain surgical procedures, if they perform the surgery in their offices, or at ambulatory surgical centers. UnitedHealthcare may enter into additional Incentive Agreements with providers during the term of your coverage. Network Providers who contract through intermediaries that contract may be subject to Incentives. UnitedHealthcare contracts with intermediaries typically, but not always, limit the nature and scope of the Incentives the group may enter into with Network Providers.

UnitedHealthcare does not pay individual Network Physicians or practitioners on a Capitated basis. However, as described above, UnitedHealthcare has negotiated a few Capitation Agreements with IPAs. UnitedHealthcare may enter into additional Capitation Agreements during the term of your coverage or terminate existing Capitation Agreements. Individual practitioners who are paid from funds available under Capitated Agreements with IPAs are generally paid on a fee-for-service basis, but some IPAs may pay individual primary care physicians on a Capitated basis. In addition, practitioners contracting through IPAs may be subject to Incentive Agreements. IPAs with which UnitedHealthcare contracts may enter into Capitation Agreements with Network Physicians. Intermediaries with which UnitedHealthcare contracts might enter into or terminate Capitation Agreements or Incentive Agreements with Network Physicians, facilities or practitioners during the term of your coverage. UnitedHealthcare may audit Network Providers' billing patterns, licensing compliance, or require documentation that services billed were provided. If the provider cannot demonstrate that services have been provided, or that the services billed are medically necessary and consistent with the services provided, UnitedHealthcare may seek to recover funds paid to the provider, reduce future payments to the provider, or take other action such as a fee reduction or withhold until the provider has corrected their behavior.

A brief description of the compensation mechanisms applicable to different providers is set forth below.

Network Physicians - The compensation mechanisms used for Network Physicians are described in the overview above. A large majority of Our Network Physicians are reimbursed by UnitedHealthcare or an intermediary on a discounted "fee-for-service" basis. Some Network Physicians have contracted with IPAs or are aligned with other Network Physicians which either: 1) accept compensation based upon a predetermined budget for the cost of Covered Services to members, or 2) are subject to an Incentive Agreement (Bonus) based on quality and utilization measurements. In addition, some physician groups are eligible to be paid a Bonus based either on the total cost incurred by UnitedHealthcare for Covered Services rendered to members who select or are assigned to a member of the physician group as their primary care physician, or other utilization measures, such as the total number of days these members (in the aggregate) spend in the hospital or percentage of referrals to certain specialists, hospitals or other facilities.

Limited License Practitioners - We reimburse Limited License Practitioners (non-Physician health care professionals) on a fee-for-service basis. UnitedHealthcare has contracted with a company to manage our physical therapy benefit and certain other therapy benefits. UnitedHealthcare has also contracted with a company to manage our chiropractic benefit. UnitedHealthcare may enter into additional Capitation and/or Incentive Agreements with other limited license practitioners during the term of your coverage.

Laboratory Services - UnitedHealthcare has contracted with laboratories who have agreed to be paid on a fee-for-service basis, with total fees limited based on a mutually agreed budget for laboratory services. The company may have a financial incentive to contain the annual aggregate cost of imaging services. We have other network labs that are paid through fee for service arrangements.

Pharmacy - We have entered into an arrangement with a national pharmacy benefit management company that, in turn, contracts with pharmacies to provide pharmacy products and services to members. The pharmacies are paid for the prescription drug products they dispense to members and they receive a fee for dispensing the prescriptions. The pharmacy benefit management company also provides certain administrative services in connection with administration of UnitedHealthcare pharmacy benefits. UnitedHealthcare may contract with pharmacies known as "specialty" pharmacies to provide certain pharmaceuticals, such as infertility drugs.

Hospital and Other Ancillary Facilities - Reimbursement to Network Facilities is made on a fee-for-service basis. For inpatient services, payment is generally on the basis of a “per day” rate, or on a case rate for an entire stay based on the diagnosis. In general, UnitedHealthcare negotiates agreements with individual hospitals or hospital systems. We do not have Capitation agreements with any of Our Network Facilities. However, we have entered into an Incentive Arrangement with an IPA for medical management of subacute facilities. The IPA pays contracting subacute facilities on a fee-for-service basis. Certain hospitals are developing their own programs to reduce unnecessary hospital inpatient stays and lengths of stays. UnitedHealthcare may enter into Capitation and/or Incentive Agreements with hospitals or physicians during the term of your coverage.

Non-Participating Providers - Providers that have not entered into contracts with UnitedHealthcare (directly or indirectly through groups), including providers in the UnitedHealthcare service area and providers outside the United Healthcare service area, are paid on a fee-for-service basis. Non-participating providers are paid based on UnitedHealthcare's determination, using various industry standards. Such standards may include lesser of Medicare, databases of competitive fees or another standard as provided in your certificate of coverage and summary of benefits. UnitedHealthcare may seek to impose bundling rules or other limitations on bills received from non-participating providers. If you received in-network benefits from an out-of-network provider and are billed by the out-ofnetwork provider, please contact us. UnitedHealthcare may audit non-participating providers’ billing patterns, licensing compliance, or require documentation that services billed were provided and that the services provided were medically necessary. Any or all of these audits may result in non-payment to the provider for these unusual or fraudulent practices. In some circumstances, this may result in balance billing to the member. If that occurs, please contact UnitedHealthcare.

Effect of Reimbursement Policies - We believe that the implementation of these reimbursement methodologies has produced the results they were designed to accomplish (i.e., access to high quality providers in our service area, and cost-effective delivery of care). Through the application of Our Quality Assurance protocols, We continuously monitor Our Providers to ensure that Our members have access to the high standards of care to which they are entitled. If a particular reimbursement policy affects a physician’s referral to a particular Network Provider, Our members have the right to request referral to a different Network Provider.

Definitions - In addition to the definitions in your Certificate, Contract, or Handbook (whichever is applicable), the capitalized words in this attachment have the following meaning:

Bonus: An incentive payment that is paid to Physicians who have met all contractual requirements to obtain the Bonus.

Capitation, Capitated: An agreed upon amount, usually a fixed dollar amount or a percentage of premium, that is paid to or budgeted for the Provider or IPA regardless of the amount of services supplied. Capitation formulas may include adjustments for benefits, age, sex, and other negotiated factors. Usually, the Capitation amounts are paid or allocated on a monthly basis.

Incentive Agreements: In general, "Withholds" and "Bonuses" are known as "Incentive Agreements." Incentive Agreements may also include higher than standard fees, or penalties for failure to adhere to UnitedHealthcare policies, such as making referrals only to Network Providers when Network Providers are capable and available to provide necessary services to members, or based on the provision of services at specific sites of service. Under such agreements, Providers are paid less (some portion of their fee is reduced or withheld) or paid more (such as in the form of a bonus) based on one or more factors that may include (but are not limited to): member satisfaction, quality of care, compliance with UnitedHealthcare policies, control of costs, and their use of services.

IPA: An IPA (independent practice association) is an organization that contracts with physicians and other health care providers.

Us, We, Our: When coverage is provided under UnitedHealthcare's HMO, it means UnitedHealthcare of New York, Inc. When coverage is provided under UnitedHealthcare's insurance company, it means UnitedHealthcare Insurance Company of New York or UnitedHealthcare Insurance Company. In addition, it can also include third parties to whom we delegate responsibility for providing administrative services relating to coverage, such as utilization management.

Withhold: Percentage of a physician's fee that is held back or reserved as an incentive to encourage appropriate and efficient medical treatment or billing.

Ohio

Important Notice to UnitedHealthcare of Ohio, Inc. Subscribers

Annual Statement for the Health Plan

As a health-insuring corporation (HIC) regulated by the Ohio Department of Insurance, UnitedHealthcare of Ohio, Inc. must comply with certain rules and regulations. Such compliance includes making available the following information annually for our plan customers. UnitedHealthcare of Ohio, Inc. serves plan customers in 88 Ohio counties. As of December 31, 2018, the HIC was providing health care benefits to 237 employer groups and more than 6,159 plan customers. UnitedHealthcare of Ohio's parent company and affiliates also provide or administer other types of health benefits plans, bringing the total number of customers served in Ohio to 503,411.

You may contact UnitedHealthcare in Ohio at the following addresses and telephone numbers:

- Executive offices are located at 5900 Parkwood Place, Dublin, OH 43016.
- Our Ohio area service offices are located at the following addresses:
  Central Ohio (Columbus and surrounding area):
  5900 Parkwood Place, Dublin, OH 43016; (513) 619-3600
  Northern Ohio (Cleveland and surrounding area):
  North Point Tower, 1001 Lakeside Avenue, Suite 1000, Cleveland, Ohio 44114-1158; (216) 420-9300
  Southwest Ohio (Cincinnati, Dayton and surrounding area):
  400 E Business Way, Suite 100, Cincinnati, Ohio 45241; (513) 619-3600

The toll-free member phone number for your area can be found on your health plan ID card.

UnitedHealthcare provides comprehensive medical care coverage to voluntary enrolled persons for a fixed monthly fee (or premium) and contracts with independent physicians, hospitals, and others to provide such care.

More than 51,177 physicians and allied health professionals, 2,367 pharmacies, and 248 hospitals were under contract with UnitedHealthcare in Ohio as of December 31, 2018. Physicians are primarily reimbursed on a fee-for-services basis. Reimbursements to hospitals and other health care providers is dependent on the negotiated terms of individual contracts. Each UnitedHealthcare plan customer receives a listing of network physicians and health care providers. These provider listings are updated twice a year – spring/summer and fall/winter. If you have questions about a contracted physician's or health care provider's hours, please call the physician's or health care provider's office directly. If you do not have the latest information and need a current listing, call the member phone number on your health plan ID card.

Please be aware that you have the right to file a complaint about the quality or appropriateness of any care you have received. UnitedHealthcare will investigate any such complaint. You may call the member phone number on your health plan ID card to file your complaint. If you wish to register a complaint with an outside agency, you may refer complaints about physician services to the State of Ohio Medical Board. You may refer complaints about treatment received at a hospital by contacting the hospital's public relations or quality assurance department, or the Ohio Department of Health. Additionally, if you have questions about the health plan's financial status, you may contact the Finance Department at UnitedHealthcare in Ohio's executive office. The address and phone number are provided above. A financial statement is available upon request for your review.

Oklahoma

Important Notice to UnitedHealthcare Subscribers in Oklahoma

Wigs/Scalp Prosthesis

An enrollee through an employer group with 51 or more employees and undergoing chemotherapy and/or radiation therapy, may be eligible to receive reimbursement up to $150 annually for the purchase of a wig or other scalp prosthesis.

Maternity

If an enrollee through an employer group has purchased benefits for pregnancy, such benefits shall include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. We will pay benefits for an inpatient stay of at least 48 hours for the mother and newborn child following a normal vaginal delivery and at least 96 hours for the mother and newborn child following a cesarean section delivery.

In addition, a post-discharge home follow-up visit for the mother and newborn will be provided by a licensed health care provider within 48 hours of discharge, if childbirth occurs at home or in a licensed birthing center.

Oklahoma Breast Cancer Patient Protection Act

UnitedHealthcare provides benefits for mastectomy and lymph node dissection including prosthetic devices and/or reconstructive surgery incident to the mastectomy. The length of a hospital stay shall not be less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

If you have undergone a partial or total mastectomy, and elect breast reconstruction in connection with a mastectomy, you are entitled to coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance.

These services will be provided in a manner determined through consultation with you and your physician, and such reconstructive surgery and any adjustments made to the non-diseased breast must occur within twenty-four months of reconstruction of the diseased breast. This coverage will have the same deductibles and copayments as other covered benefits. For questions, call the member phone number located on your health plan ID card.

Oregon

Important Notice for UnitedHealthcare Subscribers in Oregon

Confidential Communication Law

The "Confidential Communication" law in Oregon allows enrollees to request that their Protected Health Information (PHI) be sent to the enrollee instead of the primary insured who pays for the enrollee's health insurance plan. Enrollees can request that they be contacted at a different mailing address, by email, or by phone. The law requires certain insurers and third party administrators to allow enrollees to do all of the following:

(a) Submit the standardized form entitled "Oregon Confidential Communication Request" which can be found on the Oregon Insurance Division website of the Department of Consumer and Business Services at www.insurance.oregon.gov. Find the form at http://www.oregon.gov/DCBS/Insurance/gethelp/health/Documents/5059.pdf

(b) Acknowledge receipt of the enrollee's request form and respond to an enrollee's confidential communications request; and

(c) Include with the acknowledgement any information the enrollee needs about the effect of the request and the process for changing the status of the request.

If you have any questions, please call the member phone number on your health plan ID card.

Hearing Loss Resources

Information and educational materials related to hearing loss are available online from organizations such as:

EPIC Hearing: https://www.epichearing.com/listenhear/resources/
Hearing Health Foundation: https://hearinghealthfoundation.org/
Hearing Loss Association of America: https://www.hearingloss.org/

This information is for general informational purposes only and not intended to be medical advice or a substitute for professional health care. Please see your physician for medical advice specific to your condition or medical needs. For benefit coverage information, call the member phone number on your health plan ID card.

Rhode Island

Important Notice for UnitedHealthcare Subscribers in Rhode Island

Rhode Island All-Payer Claims Database Member Opt-Out Notification

State law requires health insurers and administrators in Rhode Island to submit certain information about plan enrollees to the Rhode Island All-Payer Claims Database (RI APCD). Information submitted by UnitedHealthcare includes your eligibility details and medical and pharmacy claims data. Personal information such as names or any other information that could be used to identify you will not be provided to the State of Rhode Island, but will be provided to a separate database that is required to keep personal information secure.

Even though your information will be kept anonymous, you have the option to not participate in the RI APCD program. **If you do not want your eligibility, medical and pharmacy claims data shared with RI DOH, you may opt-out at any time.**

To opt-out, visit the RI APCD Opt-Out website at www.riapcd-optout.com, or call the Rhode Island Health Insurance Consumer Support Line (RI-REACH) toll-free at 1-855-747-3224 to ask questions about the opt-out process. UnitedHealthcare will be contacted by the RI DOH to confirm your exclusion from our RI APCD data submission.

You may register opt-out preferences on behalf of any minors covered under your plan. Each adult individual in your family, who chooses not to participate in the RI APCD, will need to optout separately.

Visit www.health.ri.gov/healthcare/about/quality/ for more information, or email questions to OHIC.RIAPCD@ohic.ri.gov.

Consumer's Right to Know About Health Plans in Rhode Island

The Consumer's Right To Know About Health Plans in Rhode Island contains information about your health plan. State law requires health plans to disclose certain facts so that you will be a better-informed consumer. This consumer disclosure document includes information about:

- Your specific health plan
- How you can obtain a comprehensive list of all participating providers available to you
- Complaints, Adverse Benefit Determinations and Appeals Rights

To access the Consumer's Right to Know About Health Plans in Rhode Island, go to https://www.uhc.com/legal/required-state-notices/rhode-island and select your health plan. The Appeals Rights Notice can also be found at https://www.uhc.com/legal/required-state-notices/rhode-island.

To learn more about how health plans operate in Rhode Island, visit the State of Rhode Island Department of Health at www.health.ri.gov.

Hard copies of all documents are available upon request by calling the member phone number on your health plan ID card.

Right to Designate a Primary Care Physician

Rhode Island state law requires insurance carriers, such as UnitedHealthcare, to allow plan members to designate a primary care provider (PCP). A PCP is a physician or other licensed health care provider that you normally go to for your health care needs. PCPs typically specialize in family practice, general practice, pediatrics or internal medicine–but you are not limited to these options. In fact, you may even choose to designate a particular practice or clinic.

Even if your health plan does not require you to designate a PCP, it's important to have a doctor who you visit on a regular basis, who knows your health history and who can help guide your care.

Texas

Important Notice to Texas Subscribers under UnitedHealthcare of Texas, Inc. and UnitedHealthcare Insurance Company

Notice of Coverage for Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- Cognitive rehabilitation therapy
- Cognitive communication therapy

- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Postacute transition services and community reintegration services, including outpatient day treatment services or other post-acute-care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or postacute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If, due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call the member phone number located on your health plan ID card, or write us at the address located in your member materials.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call the member phone number located on your health plan ID card, or write us at the address located in your member materials.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and
(b) a prostate-specific antigen test for each covered male who is
    (1) at least 50 years of age; or
    (2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call the member phone number located on your health plan ID card, or write us at the address located in your member materials.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call the member phone number located on your health plan ID card, or write us at the address located in your member materials.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
(b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call the member phone number located on your health plan ID card, or write us at the address located in your member materials.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If you have questions, please call the member phone number located on your health plan ID card.

Utah

Important Notice to UnitedHealthcare of Utah, Inc. Subscribers

To assure adequate immunization and to control disease outbreaks, the immunization record of each Utah child is included in the Utah Statewide Immunization Information System (USIIS). A parent or guardian may withdraw a child from the system. To withdraw any family member from USIIS, submit a withdrawal form must be submitted to the Utah Statewide Immunization Information System. The form is available at the USIIS web site: www.usiis.org.

Vermont

Important Notice to UnitedHealthcare Plan Subscribers that Reside in Vermont

Your policy or certificate is not subject to regulation by Vermont.

Virginia

Important Notice to Virginia Subscribers under UnitedHealthcare Insurance Company of the River Valleyor UnitedHealthcare Plan of the River Valley, Inc.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, please call the member phone number on your health plan ID card.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218-1157;
bureauofinsurance@scc.virginia.gov; or 804-371-9691 or toll-free at 1-877-310-6560.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available. We recommend that you familiarize yourself with our grievance procedure and make use of it before taking any other action.

UnitedHealthcare of the River Valley, Inc. is subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

UnitedHealthcare of the River Valley, Inc. provides health care services to its members in the following areas in Virginia: counties of Alleghany, Bedford, Bland, Botetourt, Buchanan, Carroll, Craig, Dickenson, Floyd, Franklin, Giles, Grayson, Henry, Lee, Montgomery, Pulaski, Roanoke, Rockbridge, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe, and the independent cities of Bristol, Buena Vista, Galax, Lexington, Martinsville, Norton, Radford, Roanoke, and Salem.

You can nominate a board member

Members of UnitedHealthcare Plan of the River Valley, Inc. who are at least 18 years old may nominate individuals to serve on the Board of Directors. Please send a signed letter that includes the name, address, telephone number, and qualifications for each individualnominated to:

UnitedHealthcare Plan of the River Valley, Inc.
Attn: CEO
1300 River Drive, Suite 200 Moline, IL 61265-1638

Note: Other Virginia notices can be found in the section titled: "Important Notice to UnitedHealthcare of Mid-Atlantic, Inc., MD-Individual Practice Association, Inc. and Optimum Choice, Inc. Subscribers."

IMPORTANT

To verify eligibility and get benefit coverage information visit myuhc.com or call the member phone number located on your health plan ID card.

Go Green

Reduce paper mailings and support our efforts to "Go Green" by electing to receive notices such as this by email. Log in to **myuhc.com** and go to **Account Settings.**

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through a UnitedHealthcare company, Neighborhood Health Partnership, Inc., UnitedHealthcare of Alabama, Inc., UnitedHealthcare of Arizona, Inc., UnitedHealthcare of Arkansas, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Florida, Inc., UnitedHealthcare of Georgia, Inc., UnitedHealthcare of Illinois, Inc., UnitedHealthcare of Kentucky, Ltd., United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare of the Midlands, Inc., UnitedHealthcare of the Midwest, Inc., United HealthCare of Mississippi, Inc., UnitedHealthcare of New England, Inc., UnitedHealthcare of North Carolina, Inc., UnitedHealthcare of Ohio, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Tennessee, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc. UnitedHealthcare of Wisconsin, Inc., or UnitedHealthcare Plan of the River Valley, Inc.

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