CALIFORNIA SCHOOLS VEBA

UnitedHealthcare®

# Acupuncture and Chiropractic Health Benefits Plan Offered by ACN Group of California, Inc.

*Schedule of Benefits and Combined Evidence of Coverage and Disclosure Form*

**CALIFORNIA SCHOOLS VEBA**

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

## Benefit Plan:

$30 Copayment per Visit

Unlimited Visits Annual Combined Maximum Benefit

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

## How to Use the Program

With this benefit, you have direct access to more than 3,000 credentialed chiropractors and over 950 credentialed acupuncturists servicing California. You are not required to pre-designate a participating provider or obtain a medical referral from your primary care physician prior to seeking chiropractic or acupuncture services. Additionally, you may change participating chiropractors or acupuncturists at any time.

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

## Annual Benefits

Benefits include chiropractic and acupuncture services that are medically necessary services rendered by a participating provider. In the case of acupuncture services, the services must be for a medically necessary diagnosis. Treatment is to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps and carpal tunnel syndrome.

In the case of chiropractic services, the services must be for a medically necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

## Calculation of Annual Maximum Benefit Limits

Each visit to a participating provider, as described below, requires a copayment by the member. A maximum number of visits per year to either a participating chiropractor and/or participating acupuncturist will apply to each member.

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

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

## Provider Eligibility

OptumHealth only contracts with duly licensed California chiropractors and acupuncturists. Members must use participating providers to receive their maximum benefit.

## Types of Covered Services

**Chiropractic Services:**

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

2. Subsequent office visits, as set forth the treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.

3. Adjunctive therapy, as set forth the treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.

4. A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

5. X-rays and laboratory tests are a covered benefit in order to examine any aspect of the member's condition.

6. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by the participating chiropractor.

**Acupuncture Services**

1. An initial examination is performed by the participating acupuncturist to determine medically necessary services to the extent consistent with professionally recognized standards of practice. At that time, a treatment plan of services will be provided. The initial examination will be provided to a member if the member seeks services from a participating acupuncturist for any injury, illness, disease, functional disorder or condition. A copayment will be required for such examination.

2. Subsequent office visits, as set forth in the treatment plan, may involve acupuncture treatment, a brief re-examination and/or a combination of services. A copayment will be required for each office visit.

3. A re-examination may be performed by the participating acupuncturist to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

## Important OptumHealth Addresses:

**Member Correspondence**

OptumHealth of California, Inc.
Attn.: Member Correspondence Unit
P.O. Box 880009
San Diego, CA 92168-0009

**Grievances and Complaints**

OptumHealth of California, Inc.
Attn.: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168-0009

## Exclusions and Limitations

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

1. Any accommodation, service, supply or other item determined by health plan not to be medically necessary;

2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;

3. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-medically necessary purposes, and related expenses for reports, including report presentation and preparation;

4. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;

5. Experimental or investigative services unless required by an external, independent review panel as described in 16.5 of the EOC;

6. Services provided at a hospital or other facility outside of a participating provider's facility;

7. Holistic or homeopathic care including drugs and ecological or environmental medicine;

8. Services involving the use of herbs and herbal remedies;

9. Treatment for asthma or addiction (including but not limited to smoking cessation);

10. Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;

11. Transportation to and from a provider;

12. Drugs or medicines;

13. Intravenous injections or solutions;

14. Charges for services provided by a provider to his or her family member(s);

15. Charges for care or services provided before the effective date of the member's coverage under the Group Enrollment Agreement or after the termination of the member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
16. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
17. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;
18. Claims by providers who or which are not participating providers, except for claims for out-of-network emergency services or urgent services, or other services authorized by health plan;
19. Ambulance services;
20. Surgical services;
21. Services relating to member education (including occupational or educational therapy) for a problem not associated with a chiropractic disorder or acupuncture disorder, unless supplied by the provider at no additional charge to the member or to health plan;
22. Non-urgent services performed by a provider who is a relative of the member by birth or marriage, including spouse or domestic partner, brother, sister, parent or child; and
23. Emergency services. If a Member believes he or she requires emergency services, the member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment**.** Medical emergencies are covered separately by the member’s medical plan.

# COMBINED EVIDENCE OF COVERAGE

# AND DISCLOSURE FORM

## ACUPUNCTURE AND CHIROPRACTIC HEALTH BENEFITS PLAN

**This "*Combined Evidence of Coverage and Disclosure Form*" discloses the terms and conditions of coverage. However, it constitutes only a summary of your acupuncture and chiropractic health benefits plan. The document entitled "Group Enrollment Agreement" must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Group Enrollment Agreement will be furnished upon request. You have the right to review this *Combined Evidence Of Coverage and Disclosure Form* prior to enrollment. If you have special health care needs, review this *Combined Evidence Of Coverage and Disclosure Form* completely and carefully to determine if this benefit provides coverage for your special needs.**

**ACN Group of California, Inc., dba OptumHealth Physical Health of California**
**P.O. Box 880009**
**San Diego, CA 92168-0009**
**619-641-7100**
**1-800-428-6337**

# TABLE OF CONTENTS


**TABLE OF CONTENTS** ..... **IX**

**INTRODUCTION** ..... **1**

**SECTION 1. DEFINITIONS** ..... **2**

1.1 Acupuncture Disorder ..... 2
1.2 Acupuncture Services ..... 2
1.3 Acupuncturist ..... 2
1.4 Annual Benefit Maximum ..... 2
1.5 Chiropractic Disorder ..... 2
1.6 Chiropractic Services ..... 2
1.7 Chiropractor ..... 2
1.8 Copayment ..... 2
1.9 Coverage Decision ..... 2
1.10 Covered Services ..... 2
1.11 Department ..... 2
1.12 Disputed Health Care Service ..... 3
1.13 Domestic Partner ..... 3
1.14 Emergency Services ..... 3
1.15 Exclusion ..... 3
1.16 Family Dependent ..... 3
1.17 Group Enrollment Agreement ..... 3
1.18 Limitation ..... 3
1.19 Medically Necessary ..... 4
1.20 Member ..... 4
1.21 Negotiated Rates Schedule ..... 4
1.22 Neuromusculoskeletal Disorders ..... 4
1.23 Participating Provider ..... 4
1.24 *Schedule of Benefits* ..... 4
1.25 Subscriber ..... 4
1.26 Urgent Services ..... 4

**SECTION 2. RENEWAL PROVISIONS** ..... **5**

**SECTION 3. PREPAYMENT OF FEES** ..... **6**

3.1 Premium Rate Schedule ..... 6
3.2 Premium Due Date and Payments ..... 6
3.3 Premium Adjustments ..... 6
3.4 Premium Rate Schedule Changes ..... 6

**SECTION 4. OTHER CHARGES** ..... **7**

**SECTION 5. ELIGIBILITY** ..... **8**

5.1 Subscriber and Family Dependents ..... 8
5.2 Changes in Eligibility ..... 9
5.3 Nondiscrimination ..... 9
5.4 Medicare ..... 9

**SECTION 6. ENROLLMENT** ..... **10**

6.1 Initial Enrollment ..... 10
6.2 Special Enrollment Period ..... 10

**SECTION 7. MEMBER EFFECTIVE DATES OF COVERAGE** ..... **11**

7.1 Effective Date ..... 11
7.2 Newborn Children ..... 11

7.3 Adopted Children ..... 11
**SECTION 8. PRINCIPAL BENEFITS AND COVERAGES ..... 12**
8.1 Chiropractic Services Description ..... 12
8.2 Acupuncture Services Description ..... 12
8.3 Urgent Services ..... 12
8.4 Emergency Services ..... 13
8.5 Second Opinions ..... 13
8.6 Continuity of Care ..... 14
8.7 Facilities ..... 16
8.8 Access to Care Guidelines ..... 16
**SECTION 9. PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS ..... 17**
9.1 Exclusions ..... 17
9.2 Limitations ..... 18
**SECTION 10. CHOICE OF PROVIDERS ..... 19**
10.1 Access to Participating Provider ..... 19
10.2 Liability of Member for Payment ..... 19
**SECTION 11. COORDINATION OF BENEFITS (COB) ..... 20**
11.1 The Purpose of COB ..... 20
11.2 Benefits Subject to COB ..... 20
11.3 Definitions ..... 20
11.4 Effect on Benefits ..... 21
11.5 Rules Establishing Order of Determination ..... 21
11.6 Reduction of Benefits ..... 22
11.7 Right to Receive and Release Necessary Information ..... 23
11.8 Facility of Payment ..... 23
11.9 Right of Recovery ..... 23
**SECTION 12. THIRD-PARTY LIABILITY ..... 24**
12.1 Member Reimbursement Obligation ..... 24
12.2 Health Plan's Right of Recovery ..... 24
12.3 Member Cooperation ..... 24
12.4 Subrogation Limitation ..... 24
**SECTION 13. MANAGED CARE PROGRAM ..... 26**
13.1 Managed Care Program ..... 26
13.2 Managed Care Process ..... 26
13.3 Appeal Rights ..... 26
13.4 Utilization Management ..... 26
**SECTION 14. REIMBURSEMENT PROVISIONS ..... 28**
**SECTION 15. RESPONSIBILITIES OF HEALTH PLAN ..... 29**
15.1 Arrangements for Covered Services ..... 29
15.2 Compensation of Providers ..... 29
15.3 Toll-Free Telephone Number ..... 29
15.4 Public Policy Committee ..... 29
15.5 Notices to Group Representatives ..... 29
15.6 Termination or Breach of a Participating Provider Contract ..... 29
**SECTION 16. GRIEVANCE PROCEDURES ..... 30**
16.1 Applicability of the Grievance Procedures ..... 30
16.2 Grievances ..... 30
16.3 Expedited Review of Grievances ..... 30
16.4 Independent Medical Review ..... 30
16.5 IMR for Experimental and Investigational Therapies ..... 31
16.6 Implementation of IMR Decision ..... 31

16.7 Exhaustion of Remedies ..... 31
16.8 Department Review ..... 31
**SECTION 17. TERMINATION OF BENEFITS ..... 33**
17.1 Basis for Termination of a Member's Coverage ..... 33
17.2 Reinstatement ..... 33
17.3 Rescission ..... 34
17.4 Return of Premiums for Unexpired Period ..... 34
17.5 Director Review of Termination ..... 34
17.6 Individual Continuation of Benefits ..... 34
**SECTION 18. GENERAL INFORMATION ..... 39**
18.1 Relationship Between Health Plan and Each Participating Provider ..... 39
18.2 Members Bound by the Group Enrollment Agreement ..... 39
18.3 Nondisclosure and Confidentiality ..... 39
18.4 Overpayments ..... 39
18.5 Confidentiality of Medical Records ..... 39
18.6 Interpretation of Benefits ..... 39
18.7 Administrative Services ..... 40
18.8 Amendments to the Plan ..... 40
18.9 Clerical Error ..... 40
18.10 Information and Records ..... 40
18.11 Preventive Health Information ..... 41

## INTRODUCTION

This document describes the terms under which ACN Group of California, Inc. *dba OptumHealth Physical Health of California* will provide an acupuncture and chiropractic benefits program to employees of **Employer Group** and their Family Dependents who have enrolled under the Group Enrollment Agreement between *OptumHealth Physical Health of California* and **Employer Group.**

Throughout this document, *OptumHealth Physical Health of California* will be referred to as the "Health Plan," **Employer Group** will be referred to as the "Group," and enrollees under the Group Enrollment Agreement will be referred to as "Members." Along with reading this publication, be sure to review the *Schedule of Benefits* and any benefit materials. The *Schedule of Benefits* provides the details of this particular Health Plan, including any Copayments that a member may have to pay when using a health care service. Together, these documents explain this coverage.

# SECTION 1. DEFINITIONS

*This Section defines some important words and phrases that are used throughout this document. Understanding the meanings of these words and phrases is essential to an understanding of the overall document.*

## 1.1 Acupuncture Disorder

"Acupuncture Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders or other conditions wherein Acupuncture Services can reasonably be anticipated to result in improvement.

## 1.2 Acupuncture Services

"Acupuncture Services" means Medically Necessary services and supplies provided by or under the direction of a Participating Provider for the treatment or diagnosis of Acupuncture Disorders.

## 1.3 Acupuncturist

"Acupuncturist" means an individual duly licensed to practice acupuncture in California.

## 1.4 Annual Benefit Maximum

"Annual Benefit Maximum" means an amount specified in the *Schedule of Benefits* which is the maximum amount that Health Plan is obligated to pay on behalf of a Subscriber for Covered Services of a particular type or category provided to a Subscriber in a given benefit year.

## 1.5 Chiropractic Disorder

"Chiropractic Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders, wherein Chiropractic Services can reasonably be anticipated to result in improvement.

## 1.6 Chiropractic Services

"Chiropractic Services" means Medically Necessary services and supplies provided by or under the direction of a Participating Provider for the diagnosis of treatment of Chiropractic Disorders.

## 1.7 Chiropractor

"Chiropractor" means an individual duly licensed to practice chiropractics in California.

## 1.8 Copayment

"Copayment" means a predetermined amount specified in the *Schedule of Benefits* to be paid by the Member each time a specific Covered Service is received. Copayments are to be paid by Members directly to the Participating Provider who or which provided the Covered Service(s) to which such Copayments apply.

## 1.9 Coverage Decision

"Coverage Decision" means the approval or denial of benefits for health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a Disputed Health Care Service.

## 1.10 Covered Services

"Covered Services" means those Medically Necessary Chiropractic Services or Acupuncture Services, including Urgent Services, to which Members are entitled under the terms of the Group Enrollment Agreement and this *Combined Evidence Of Coverage and Disclosure Form*, as such documents may be amended from time to time in accordance with their terms.

## 1.11 Department

"Department" means the California Department of Managed Health Care.

## 1.12 Disputed Health Care Service

"Disputed Health Care Service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not Medically Necessary.

## 1.13 Domestic Partner

"Domestic Partner" means a person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is eighteen (18) years of age or older;
- Is mentally competent to consent to contract;
- Resides with the Subscriber and intends to do so indefinitely;
- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

## 1.14 Emergency Services

"Emergency Services" means services provided for a medical condition (including a psychiatric medical condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part.

## 1.15 Exclusion

"Exclusion" means any service, equipment, supply, accommodation or other item specifically listed or described as excluded in the Group Enrollment Agreement or this *Combined Evidence Of Coverage and Disclosure Form*.

## 1.16 Family Dependent

"Family Dependent" means an individual who is a member of a Subscriber's family and who is eligible and enrolled in accordance with all applicable requirements of the Group Enrollment Agreement, and on whose behalf Health Plan has received premiums.

## 1.17 Group Enrollment Agreement

"Group Enrollment Agreement" means the agreement entered into by and between ACN Group of California, Inc. of California and Group through which you enroll for coverage.

## 1.18 Limitation

"Limitation" means any provision, other than an Exclusion, contained in the Group Enrollment Agreement, this *Combined Evidence Of Coverage and Disclosure Form* or the attached *Schedule of Benefits*, which limit the covered Chiropractic Services or Acupuncture Services to which Members are entitled.

## 1.19 Medically Necessary

"Medically Necessary" means:

a. **Chiropractic:** Necessary and appropriate for the diagnosis or treatment of neuromusculoskeletal disorders; established as safe and effective; and furnished in accordance with generally accepted chiropractic practice and professional standards to treat Neuromusculoskeletal Disorders.

b. **Acupuncture:** Necessary and appropriate for the diagnosis or treatment of an accident, illness or condition; established as safe and effective; and furnished in accordance with generally accepted acupuncture practice and professional standards.

## 1.20 Member

"Member" means a Subscriber or a Family Dependent.

## 1.21 Negotiated Rates Schedule

"Negotiated Rates Schedule" means the schedule of rates which a Participating Provider has agreed to accept as payment in full for Covered Services provided to Members.

## 1.22 Neuromusculoskeletal Disorders

"Neuromusculoskeletal Disorders" means conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction is the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related to neurological manifestations or conditions.

## 1.23 Participating Provider

"Participating Provider" means any Chiropractor or Acupuncturist who is qualified and duly licensed or certified by the State of California to furnish Chiropractic Services or Acupuncture Services and has entered into a contract with the Health Plan to provide Covered Services to Members.

## 1.24 *Schedule of Benefits*

"*Schedule of Benefits*" means the summary of Copayments, Annual Benefit Maximums, Exclusions and Limitations applicable to Member's chiropractic and acupuncture benefits program. The *Schedule of Benefits* is Attachment A to this *Combined Evidence Of Coverage and Disclosure Form*.

## 1.25 Subscriber

"Subscriber" means an employee or retiree who is eligible and enrolled in accordance with all applicable requirements of this Agreement, and on whose behalf the Group has made premium payments.

## 1.26 Urgent Services

"Urgent Services" means services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

## SECTION 2. RENEWAL PROVISIONS

After the Initial Term, the Group Enrollment Agreement will automatically renew from year to year for additional twelve (12)-month periods ("Subsequent Terms") on the same terms and conditions unless terminated by the Group in accordance with Section 22 of the Group Enrollment Agreement. However, Health Plan has reserved the right to change the Premium Rate Schedule in accordance with Section 5.4 of the Group Enrollment Agreement and any other term or condition of the Group Enrollment Agreement upon thirty-one (31) days' prior written notice to the Group.

# SECTION 3. PREPAYMENT OF FEES

## 3.1 Premium Rate Schedule

The Group is responsible for timely payment to Health Plan of the applicable total monthly premium. The Group will notify Members of the portion of that charge, if any, which Members are required to pay. The only other charges to be paid by Members are the Copayments for the Covered Services received. The full premium cost per Member will be **as determined by Group**.

## 3.2 Premium Due Date and Payments

The first day of a month of coverage under the Group Enrollment Agreement is called the "Premium Due Date." The Group has agreed to pay to Health Plan on or before the Premium Due Date the applicable total monthly premium for each Member enrolled as of such date as determined by Health Plan by reference to Health Plan Member records.

Premium payments which remain outstanding subsequent to the end of the grace period shall be subject to a late penalty charge of one percent (1.00%) of the total premium amount due calculated for each thirty-one (31)-day period or portion thereof during which the premium remains outstanding. In addition, subject to Section 17 of this *Combined Evidence Of Coverage and Disclosure Form*, Health Plan may terminate coverage of a Member whose premium is unpaid. Only Members for whom payment is received by Health Plan will be eligible for Covered Services, and then only for the period covered by such payments.

## 3.3 Premium Adjustments

If a Member enrolls on or before the 15th day of a month, Group has agreed to pay to Health Plan on or before the next Premium Due Date an additional total monthly premium for such Member for the month in which the Member enrolled. In the event that a Member enrolls after the 15th day of the month, no total monthly premium is due for such Member for the month in which the Member enrolled.

## 3.4 Premium Rate Schedule Changes

Health Plan may change the Premium Rate Schedule at the end of the Initial Term or any Subsequent Term by giving no less than thirty-one (31) days' prior written notice to the Group. The Premium Rate Schedule will not be revised more often than one (1) time during each Initial Term and one (1) time during each of any Subsequent Term/s. However, if a change in the Group Enrollment Agreement is necessitated by a change in the applicable law or in the interpretation of applicable law, and if such change results in an increase of Health Plan's risk or expenses under the Group Enrollment Agreement, or if there is a material change in the number of eligible subscribers of the Group, Health Plan may change the Premium Rate Schedule at any time upon thirty-one (31) days' prior written notice to the Group pursuant to the Group Enrollment Agreement requirements. Any such change will not be taken into account in determining whether the foregoing limits on revisions to the Premium Rate Schedule have been reached.

## SECTION 4. OTHER CHARGES

Each Member is personally responsible for all Copayments listed in the *Schedule of Benefits* applicable to Covered Services received by the Member. Members must pay all applicable Copayments to the Participating Provider who provided the Covered Services to which such payments apply at the time such services are rendered.

# SECTION 5. ELIGIBILITY

## 5.1 Subscriber and Family Dependents

To be eligible to enroll as a Subscriber in this benefit plan, a person must meet the eligibility guidelines established by the Group.

If the Group does not have eligibility guidelines, Health Plan will use the following guidelines for eligibility:

**5.1.1** Full-time employees working thirty (30) or more hours per week.

**5.1.2** Family Dependents who are persons listed on an enrollment form completed by the Subscriber, and are one of the following:

**5.1.2.1** The Subscriber's lawful spouse in a marriage that has been duly licensed and registered in accordance with the laws of the jurisdiction in which it occurred or Domestic Partner; or

**5.1.2.2** A child or stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner by birth, legal adoption or court appointed legal guardianship, under the age of twenty-six (26) or as required by state or federal laws or regulations; if adopted, such child is eligible on the date the child was in custody of the Subscriber or the Subscriber's spouse or Domestic Partner; or

**5.1.2.3** A child as defined in Section 5.1.2.2 above who is, and continues to be, both incapable of self-sustaining employment by reason of mental or physical handicap, and chiefly dependent upon the Subscriber for economic support and maintenance, provided that such child meets the requirements of either (A) or (B) below:

(A) The child is a Family Dependent continuously enrolled hereunder prior to attaining the applicable limiting age, and proof of such incapacity and dependency is furnished to Health Plan by the Subscriber within thirty-one (31) days of the child's attainment of the applicable limiting age; or

(B) The handicap started before the child reached the applicable limiting age, and the Group was previously enrolled in another health benefits program that included chiropractic or acupuncture benefits that covered the child as a handicapped dependent immediately prior to the Group enrolling with Health Plan.

(C) Subsequent proof of continuing incapacity and dependency may be required by Health Plan, but not more frequently than annually after the two-year period following the child attaining the applicable limiting age. Health Plan's determination of eligibility is conclusive; or

A newborn child of the Subscriber or Subscriber's spouse. Such newborn children automatically have coverage for the first thirty-one (31) days of life. Coverage after thirty-one (31) days is conditioned on the Subscriber enrolling the newborn as a Family Dependent, and paying any applicable premium and charges due and owing from the date of birth, within thirty-one (31) days following birth.

The following are not considered Family Dependents:

(A) A foster child

(B) A grandchild

**5.1.3** Eligible persons must reside in the U.S.

**5.1.4** If both spouses or Domestic Partners are eligible persons of the Group, each may enroll as a Subscriber or be covered as an enrolled Family Dependent of each other, but not both.

**5.1.5** If both parents of a dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Family Dependent.

## 5.2 Changes in Eligibility

The Subscriber is responsible for notifying the Group of any changes that affect the eligibility of the Subscriber or a Family Dependent for coverage. Any changes which affect a Subscriber's eligibility status including, but not limited to, death, divorce, marriage, or attainment of limiting age, require notice to Health Plan from the Subscriber or the Group within thirty-one (31) days of the date of the change in status. Coverage for a Member who no longer meets applicable eligibility requirements shall terminate upon the earlier of: (i) Health Plan’s receipt of written notice of the Member’s change in status; or (ii) the last day of the calendar month in which eligibility ceased.

## 5.3 Nondiscrimination

Except as otherwise provided in the Group Enrollment Agreement, Health Plan will require Participating Providers to make Covered Services available to Members in the same manner, in accordance with the same standards, and with no less availability as Participating Providers provide services to their other patients. Participating Providers shall not discriminate against any Members in the provision of Covered Services on account of race, sex, color, religion, national origin, ancestry, age, physical or mental handicap, health status, disability, genetic characteristics, need for medical care, sexual preference, or veteran’s status.

## 5.4 Medicare

Benefits under the benefit plan are not intended to supplement any coverage provided by Medicare. In some circumstances, Members who are eligible for or enrolled in Medicare may also be enrolled under the benefit plan, subject to Section 11.

# SECTION 6. ENROLLMENT

## 6.1 Initial Enrollment

Members who elect enrollment through the Group are automatically enrolled for coverage under the benefit plan by the Group.

## 6.2 Special Enrollment Period

Subscribers who do not enroll for coverage when first eligible may enroll themselves and Family Dependents for coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (i) The eligible Subscriber and/or Family Dependents had existing health coverage under another plan at the time of initial eligibility; or (ii) Coverage under the prior plan was terminated as a result of loss of eligibility. Subscribers must enroll themselves and any eligible Family Dependents by submitting to the Group the applicable enrollment form within 31 days of the date coverage under the prior plan terminated. The Group shall promptly forward to Health Plan a copy of each enrollment form received by the Group in accordance with this Section 6.2.

# SECTION 7. MEMBER EFFECTIVE DATES OF COVERAGE

## 7.1 Effective Date

Subject to the Group's payment of the applicable total monthly premium for each Member and subject to the Group's submission to Health Plan prior to the first day of each month of a listing of each Member eligible to receive Covered Services, including all prospective Members, within thirty-one (31) days of the date of such Member's first becoming eligible, coverage under the Group Enrollment Agreement will become effective for said Members on the effective date of coverage specified by the Group.

## 7.2 Newborn Children

For newborn children, coverage shall become effective immediately after birth for thirty-one (31) days, and shall continue in effect thereafter only if the newborn is eligible and enrolled by the Subscriber within thirty-one (31) days following the newborn's birth.

## 7.3 Adopted Children

For adopted children, coverage shall become effective immediately after the child is placed in the custody of the Subscriber or the Subscriber's spouse or Domestic Partner for adoption for thirty-one (31) days, and shall continue in effect thereafter only if the child is eligible and enrolled by the Subscriber within thirty-one (31) days following the child's placement in the custody of the Subscriber or the Subscriber's spouse or Domestic Partner for adoption.

# SECTION 8. PRINCIPAL BENEFITS AND COVERAGES

*Members are entitled to receive the Covered Services described in this Section when such services are Medically Necessary for the treatment of a Member's Chiropractic Disorder or Acupuncture Disorder, subject to all applicable Exclusions and Limitations and Benefit Maximums, as well as all other terms and conditions contained in this Combined Evidence Of Coverage and Disclosure Form and the Group Enrollment Agreement.*

## 8.1 Chiropractic Services Description

Chiropractic Services provided include:

(A) Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system;

(B) Initial patient examinations;

(C) Subsequent visits for further evaluation of a Member's condition;

(D) Adjunctive therapies, such as ultrasound, hot/cold packs, electrical muscle stimulation, and other therapies;

(E) Examination of any aspect of the Member's condition by means of radiological (x-ray) diagnostic imaging or clinical laboratory tests;

(F) Spinal and Extraspinal Treatment; and

(G) Durable Medical Equipment (limited to $50 per year).*

## 8.2 Acupuncture Services Description

Acupuncture Services provided include:

(A) Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions;

(B) Initial patient examinations;

(C) Subsequent visits for further evaluation of a Member's condition; and

(D) Adjunctive therapies such as moxibustion, cupping and acupressure.

## 8.3 Urgent Services

Urgent Services are services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed. Members are entitled to receive Urgent Services, including Urgent Services received outside the Health Plan's service area, when such services are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

* **Durable Medical Equipment or DME** means equipment that can withstand repeated use by Members outside a provider's office or facility, is primarily or customarily used in the treatment of Chiropractic Disorders, and is generally not useful to a Member in the absence of a Chiropractic Disorder. Members should refer to the *Schedule of Benefits* at Attachment A for a description of the DME covered under the benefit plan, and Section 9.2 for a description of the limitations applicable to DME.

## 8.4 Emergency Services

If a Member believes he or she requires Emergency Services as defined in Section 1.14, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Members are encouraged to use appropriately the 911 emergency response system, in areas where the system is established and operating, when they have an emergency condition that requires an emergency response.

## 8.5 Second Opinions

Where, as a result of a Chiropractic Disorder or Acupuncture Disorder, a treatment plan is recommended by a Participating Provider, Health Plan, Member or the treating Provider on a Member's behalf, may request that a second opinion be obtained from a Participating Provider qualified to diagnose and treat the specific Chiropractic Disorder or Acupuncture Disorder.

### 8.5.1 Second Opinion Requests

A Member may request a second opinion when the Member has concerns that may include, but are not be limited to, any of the following:

(A) The Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to a serious chronic condition;

(B) The Member finds that the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating chiropractic or acupuncture health professional is unable to diagnose the condition;

(C) The Member determines that the treatment plan in progress is not improving the chiropractic or acupuncture health condition of the Member within an appropriate period of time given the diagnosis and plan of care; or

(D) The Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Members may request a second opinion by contacting Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

When the request originates with the Member and concerns care from a Participating Provider, a second opinion is to be provided by any provider of the Member's choice from within the Health Plan's network. The provider must be of the same or equivalent specialty, acting within his or her scope of practice and possess clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for the second opinion.

If there is no Participating Provider within the network who meets the standard specified above, then the Health Plan shall authorize a second opinion by an appropriately qualified health professional outside of the Health Plan's provider network.

All second opinions requested or certified by Health Plan, including all related diagnostic tests, are Covered Services. If Health Plan approves a Member request for a second opinion, the Health Plan shall be responsible for the costs of such opinion. The Member shall be responsible only for the costs of applicable Copayments that the Health Plan requires for similar referrals.

If an out-of-plan second opinion is authorized by the Health Plan, the Member's Copayment will be the same as the in-network Copayment payable to the same type of provider.

A second opinion authorized by the Health Plan shall not count against the Member's benefit limitation. Unless specifically authorized by the Health Plan, any **additional** medical opinions not within the contracted network shall be the responsibility of the Member.

### 8.5.2 Plan Review of Requests for Second Opinions

Health Plan's authorization or denial of a request for a second opinion shall be provided in an expeditious manner. All non-urgent requests will be resolved within 72 hours of the Health Plan's receipt of a request for a second opinion.

An urgent request, when the Member's condition is such that the Member faces an imminent or serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental to the Member's ability to regain maximum function, will be expedited and resolved (authorized or denied) whenever possible within 24 hours but not to exceed 72 hours from the Plan's receipt of the request.

The Health Plan will deny a Member's request for a second opinion only in the absence of applicable benefits. In any such case, the Health Plan shall notify the Member in writing of the reasons for the denial and shall inform the Member of the right to file a grievance with the Health Plan.

A copy of the Health Plan's Policy and Procedure regarding second opinions is available to Members and the public upon request. Members may request a copy of the Policy and Procedure by contacting the Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

## 8.6 Continuity of Care

Upon a Member's request, Health Plan will provide for the completion of Covered Services that are being rendered by a Terminated Provider or a Non-Contracting Provider when the Member is receiving services from that provider for an "acute condition," a "serious chronic condition," or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage, or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates. Members who wish to request continuity of care coverage or a copy of Health Plan's Policy and Procedure regarding continuity of care should contact the Health Plan's Customer Services Department at the toll-free telephone number listed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*, or by writing to the Customer Services Department at the following address:

Customer Services Department
OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009

Members may also fax their questions or requests to Health Plan at (619) 641-7185, or contact Health Plan online at www.myoptumhealthphysicalhealthofca.com.

If a Member requests to keep their provider, they should include in the request the name of the provider, the provider's contact information, and information regarding the condition for which the Member is receiving care from the provider.

After Health Plan has received all information necessary, Health Plan will complete its review in a timely manner appropriate for the nature of the Member's clinical condition. Health Plan will mail the Member a written notification of its decision within five (5) business days of its decision.

Except as otherwise provided by applicable law:

**8.6.1** Health Plan shall, at the request of a Member, provide for continuity of care for the Member by a Terminated Provider or by a Non-Contracting Provider who has been providing care for an acute condition, a serious chronic condition, or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates.

**8.6.2** In cases involving an acute condition, Health Plan shall furnish the Member with Covered Services for the duration of the acute condition.

**8.6.3** In cases involving a serious chronic condition, Health Plan shall furnish the Member with Covered Services for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Participating Provider as determined by Health Plan in consultation with the terminated provider, consistent with good professional practice.

**8.6.4** In cases involving the care of a newborn child between birth and age 36 months, completion of Covered Services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.

**8.6.5** The payment of any Copayments by the Member during the period of continuation of care shall be the same any Copayments that would be paid by the Member when receiving Covered Services from a Participating Provider.

**8.6.6** **Definitions.** For purposes of this Section 8.6, the following definitions will apply:

**8.6.6.1** **"**Acute condition" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

**8.6.6.2** "Serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

**8.6.6.3** **"**Provider" is an acupuncturist or chiropractor duly licensed under California law to deliver or furnish acupuncture or chiropractic services.

**8.6.6.4** "Participating Provider" has the same meaning as stated in Section 1.23 of this *Combined Evidence Of Coverage and Disclosure Form*.

**8.6.6.5** "Non-Contracting Provider" is a Provider who is not party to a contract with the Plan to provide acupuncture or chiropractic services.

**8.6.6.6** "Terminated Provider" is a Provider whose contract with the Plan has terminated or has not been renewed.

**8.6.7** **Terminated Providers.** In the event the criteria listed in the continuity of care section (8.5) are met; Health Plan will require a Terminated Provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that applied to the provider prior to termination, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Terminated Provider does not agree to comply or does not comply with these contractual terms and conditions, Health Plan will not continue the Terminated Provider's services beyond the contract termination date. In such cases, Health Plan will refer the Member to a Participating Provider.

Unless otherwise agreed by the Terminated Provider and Health Plan, the services rendered shall be compensated at rates and methods of payment similar to those used by Health Plan for Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Terminated Provider. Health Plan will not continue the services of a Terminated Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 8.6.7. In such cases, Health Plan will refer the Member to a Participating Provider.

**8.6.8** **Non-Contracting Providers.** In the event the criteria listed in the continuity of care section (8.5) are met; Health Plan will allow a Non-Contracted Provider to treat a Member, as long as the provider agrees in writing to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Non-Contracting Provider, including, but not limited to, credentialing, utilization review, peer review, and quality assurance

requirements. If the Non-Contracting Provider does not agree to comply or does not comply with these contractual terms and conditions, Health Plan will not continue the provider's services. In such cases, Health Plan will refer the Member to a Participating Provider.

Unless otherwise agreed upon by the Non-Contracting Provider and Health Plan, the services rendered shall be compensated at rates and methods of payment similar to those used by Health Plan for Participating Providers providing similar services who are practicing in the same or a similar geographic area as the Non-Contracting Provider. Health Plan will not continue the services of a Non-Contracted Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 8.6.8. In such cases, Health Plan will refer the Member to a Participating Provider.

**8.6.9** **Limitations.** Members are not eligible to keep their provider if the provider does not agree to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as your provider. Members are not eligible to keep their provider if their provider had a contract with Health Plan which was terminated or not renewed for reasons relating to a medical disciplinary cause or reason, fraud, or other criminal activity. New Members are not eligible to keep their provider if the Member had the option to continue with another health plan or provider and voluntarily chose to change health plans. In each of these cases, Health Plan will refer the Member to a Participating Provider. Health Plan will not cover services that are not otherwise covered under a Member's benefit plan.

**8.6.10** If a Member is not satisfied with Health Plan's decision, a Member may file a grievance with the Health Plan subject to the terms and instructions included at Section 15 of this *Combined Evidence Of Coverage and Disclosure Form*.

## 8.7 Facilities

During Health Plan's business hours (Monday through Friday, 8:30 a.m. through 5:00 p.m.) services provided through Health Plan's 24-hour toll-free telephone number referenced in Section 15.3 include referral of Members for Covered Services and responding to Member inquiries and questions regarding Covered Services. After hours, Health Plan will maintain an answering service with recorded instructions for members who call after-hours.

Health Plan: (i) maintains an after-hours answering service with recorded instructions for members who call after-hours, and (ii) requires its Participating Providers to provide Members with telephone access to a Participating Provider twenty-four (24) hours a day, seven (7) days a week**.**

Participating Providers must be available for office hours during normal business hours (generally Monday through Friday between 9:00 a.m. and 5:00 p.m.). Members may obtain office hours and emergency information from a Participating Provider's answering machine any time staff is not able to answer the phone. Members may also leave a message twenty-four (24) hours a day.

## 8.8 Access to Care Guidelines

Health Plan ensures that Members, during normal business hours, can speak to a customer service representative and will not have a waiting time that exceeds ten (10) minutes. Health Plan's standards for access to care from the time of the request of an appointment from a member are as follows:

| **Type of Care** | **Timing** |
|---|---|
| Urgent Care | Within 24 hours |
| Routine care | Within ten (10) business days |
| Urgent Patient calls | Returned within 30 minutes |

# SECTION 9. PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

## 9.1 Exclusions

The following accommodations, services, supplies and other items are specifically excluded from coverage:

(A) Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;

(B) Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;

(C) Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care.

(D) Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;

(E) Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;

(F) Experimental or investigative services unless required by an external, independent review panel as described in Section 16.5;

(G) Services provided at a hospital or other facility outside of a Participating Provider's facility;

(H) Holistic or homeopathic care including drugs and ecological or environmental medicine;

(I) Services involving the use of herbs and herbal remedies;

(J) Treatment for asthma or addiction (including but not limited to smoking cessation);

(K) Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;

(L) Transportation to and from a provider;

(M) Drugs or medicines;

(N) Intravenous injections or solutions;

(O) Charges for services provided by a Provider to his or her family Member(s);

(P) Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;

(Q) Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;

(R) Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;

(S) Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services Urgent Services, or other services authorized by Health Plan;

(T) Ambulance services;

(U) Surgical services;

(V) Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder or Acupuncture Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;

(W) Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child;

(X) Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Medical Emergencies are covered by the Member's medical plan rather than OptumHealth Physical Health of California

## 9.2 Limitations

The *Schedule of Benefits* attached as Attachment A lists the Copayments and Annual Benefit Maximums that are applicable to, and that operate as Limitations on, Covered Services. Coverage for Durable Medical Equipment is limited to $50 per year.

# SECTION 10. CHOICE OF PROVIDERS

## 10.1 Access to Participating Provider

Each Member who requests that Covered Services be provided will be able to choose from any Health Plan Participating Provider who will coordinate the Covered Services to be received by the Member. Members may request access to a Participating Provider by contacting Health Plan's Customer Services department at the toll-free telephone number printed on the front page of this *Combined Evidence Of Coverage and Disclosure Form*.

## 10.2 Liability of Member for Payment

If a Member chooses to obtain out-of-network Chiropractic Services or Acupuncture Services (other than Urgent Services) from a provider other than a Participating Provider, the Member will be liable for payment for such services. **Services (other than Urgent Services) performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child are not covered.**

# SECTION 11. COORDINATION OF BENEFITS (COB)

## 11.1 The Purpose of COB

The provisions of this Section establish a procedure through which Health Plan or a Participating Provider may, in certain instances, recover a portion of the costs of Covered Services from an insurer or other third-party payor which also provides indemnity or other coverage for Chiropractic Services or Acupuncture Services provided to a Member. The Group and all Members shall cooperate with Health Plan in the administration of these provisions.

## 11.2 Benefits Subject to COB

All of the benefits provided under this Agreement are subject to COB in accordance with the provisions of this Section 11.

## 11.3 Definitions

The following definitions are applicable to the provisions of this Section only:

**11.3.1** "Plan" means any plan providing chiropractic and acupuncture benefits for, or by reason of, Chiropractic Services and Acupuncture Services, which benefits are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs other than Medi-Cal, or California Children's Services, and any coverage required or provided by any statute.

**11.3.2** The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

**11.3.2.1** The term "Plan" shall include:

**11.3.2.1.1** All group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to Section 10270.97 of the California Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to 10270.2(b) or (e) which contain non-duplication of benefits or excess policy provisions.

**11.3.2.1.2** "Medicare" or other similar governmental benefits, provided that:

(A) The definition of "Allowable Expenses" shall only include the chiropractic and acupuncture benefits as may be provided by the governmental program;

(B) Such benefits are not by law excess to this Plan; and

(C) The inclusion of such benefits is inconsistent with any other provision of this Agreement.

**11.3.2.1.3** The term "Plan" shall not include:

**11.3.2.1.3.1** Individual or family policies, or individual or family subscriber contracts, except as otherwise provided herein.

**11.3.2.1.3.2** Any entitlements to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the California Welfare and Institutions Code, or benefits under the California Children's Services under Section 10020 of the Welfare and Institutions Code, or any other coverage

provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.

**11.3.2.1.3.3** Medical payment benefits customarily included in traditional automobile contracts.

**11.3.3** "Plan" means that portion of this Agreement that provides the benefits that are subject to this Section.

**11.3.4** "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and benefit paid.

**11.3.5** "Claim Determination Period" means a calendar year.

## 11.4 Effect on Benefits

**11.4.1** This Section 11 shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:

**11.4.1.1** The value of the benefits that would be provided by this Plan in the absence of this Section 11, and

**11.4.1.2** The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

**11.4.2** As to any Claim Determination Period to which this Section is applicable, the benefits that would be provided under this Plan in the absence of this provision for Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in Section 11.4.3 immediately below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefore.

**11.4.3** If another Plan which is involved in Section 11.4.2 immediately above and which contains: provisions coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and the rules set forth in Section 11.5 immediately below would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

## 11.5 Rules Establishing Order of Determination

For the purpose of Section 11.4, the rules establishing the order of determination are:

**11.5.1** The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as dependent.

**11.5.2** Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of the benefits.

**11.5.3** In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

**11.5.4** In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as dependent of the parent without custody.

**11.5.5** In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced where there is a court decree which would otherwise establish financial responsibility for the costs of Chiropractic Services or Acupuncture Services with respect to the child, then, notwithstanding Sections 11.5.3 and 11.5.4, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

**11.5.6** When Sections 11.5.1 through 11.5.5 do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

**11.5.6.1** The benefits of a Plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

**11.5.6.2** If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining benefits after the other, then Section 11.5.6.1 shall not apply.

In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this provision.

If a claimant's effective date of coverage under a given Plan is subsequent to the date the other carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this provision, that the claimant's length of time covered under the Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his or her coverage under that Plan has been in force.

## 11.6 Reduction of Benefits

When this Section 11 operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan. Health

Plan may not decrease, in any manner, the benefits stated herein, except after a period of at least thirty (30) days from the date of the postage paid mailing to the Group.

## 11.7 Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section 11 of this Plan or any provision of similar purpose of any other Plan, to the extent permitted by applicable law, including the Health Insurance Portability and Accountability Act of 1996 and the Confidentiality of Medical Information Act, the Plan may release to or obtain from any insurance Health Plan or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

## 11.8 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

## 11.9 Right of Recovery

Whenever payments have been made by the Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Section 11, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to, for, or with respect to whom such payments were made, any insurers, any service plans, or any other organizations.

# SECTION 12. THIRD-PARTY LIABILITY

## 12.1 Member Reimbursement Obligation

If a Member receives payment by way of a third-party suit or settlement for Covered Services provided or paid for by Health Plan, the Member shall be obligated to reimburse Health Plan for the actual costs incurred by Health Plan for such Covered Services, but no more than the amount the Member recovers on account of the condition for which Covered Services were provided, exclusive of any amounts awarded in a suit as compensatory damages for any items other than the expenses of Chiropractic Services and Acupuncture Services and any amounts awarded as punitive damages.

## 12.2 Health Plan's Right of Recovery

Health Plan shall have a lien on all funds recovered by a Member from a third party pursuant to Section 12.1 immediately above. Such lien shall not exceed the sum of the reasonable costs actually paid by Health Plan to perfect the lien and the amount actually paid by Health Plan to any treating provider. If the Member engaged an attorney, the lien may not exceed one-third (1/3) of the monies due to the Member under any final judgment, compromise, or settlement agreement. If the Member did not engage an attorney, the lien may not exceed one-half (1/2) of the monies due to the Member under any final judgment, compromise, or settlement agreement. Health Plan may give notice of such lien to any party who may have contributed to the loss.

## 12.3 Member Cooperation

The Member shall take such action, furnish such information (including responding to requests for information about any accident or injuries and making court appearances) and assistance, and execute such instruments (including a written confirmation of assignment, and consent to release medical records) as Health Plan may require to facilitate enforcement of Health Plan's rights under this Section 12, and shall take no action that tends to prejudice such rights. Any Member who fails to cooperate in Health Plan's administration of this Section 12 shall be responsible for the amount otherwise recoverable by Health Plan under this Section.

## 12.4 Subrogation Limitation

Health Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, from any or all of the following:

(A) Third parties, including any person alleged to have caused Member to suffer injuries or damages;

(B) Member's employer;

(C) Any person or entity obligated to provide benefits or payments to Member, including benefits or payments for underinsured or uninsured motorist protection (collectively referred to as "Third Parties.")

Health Plan has the right to be subrogated to the Member's rights for all amounts recoverable by Health Plan under this Section 12. Health Plan's rights under this Section 12.4 include the right to bring suit against the third party in the Member's name.

**Member agrees:**

(A) To assign all rights of recovery against Third Parties, to the extent of the actual costs of Covered Services provided or paid for by Health Plan, plus reasonable costs of collection;

(B) To cooperate with Health Plan in protecting Health Plan's legal rights to subrogation and reimbursement;

(C) That Health Plan's rights will be considered as the first priority claim against Third Parties, to be paid before any other of Member's claims are paid;

(D) That Member will do nothing to prejudice Health Plan's rights under this provision, either before or after the need for services or benefits under this document;

(E) That Health Plan may, at Health Plan's option, take necessary and appropriate action to preserve Health Plan's rights under these subrogation provisions, including filing suit in Member's name;

(F) That regardless of whether or not Member has been fully compensated, Health Plan may collect from the proceeds of any full or partial recovery that Member or Member's legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the actual costs incurred by Health Plan for Covered Services provided or paid for by Health Plan;

(G) To hold in trust for Health Plan's benefit under these subrogation provisions any proceeds of settlement or judgment;

(H) That Health Plan shall be entitled to recover from Member reasonable attorney fees incurred in collecting proceeds held by Member;

(I) That Member will not accept any settlement that does not fully compensate or reimburse Health Plan without Health Plan's written approval.

# SECTION 13. MANAGED CARE PROGRAM

## 13.1 Managed Care Program

The Managed Care Program is the program by which Health Plan determines whether services or other items are Medically Necessary and directs care in the most cost-efficient manner. The Managed Care Program includes, but is not limited to, requirements with respect to the following: concurrent and retrospective utilization review; and quality assurance activities. The Managed Care Program requires the cooperation of Members, Participating Providers, and Health Plan. All Participating Providers have agreed to participate in Health Plan's Managed Care Program.

## 13.2 Managed Care Process

Health Plan's Utilization Management Committees will have program oversight for Chiropractic Services and Acupuncture Services provided, or to be provided, to Members under this Agreement in order to determine: (i) whether the services are/were Medically Necessary; (ii) the appropriateness of the recommended treatment setting; (iii) the required duration of treatment; (iv) whether the recommended treatment qualifies as a Covered Service; and (v) whether any Limitations apply.

## 13.3 Appeal Rights

All decisions made by Health Plan in connection with the Managed Care Program may be appealed by the Member through the Grievance Procedure set forth in Section 16.

## 13.4 Utilization Management

Health Plan utilizes the following process to authorize, modify, or deny services under benefits provided by the Health Plan.

**13.4.1** **Utilization Review**. Utilization review occurs as the services are provided (concurrent), or after the services have been provided (retrospective). The Utilization Review Process requires health care providers to submit the authorization request forms. Utilization review will not be conducted more frequently than is reasonably required to assess whether the health care services under review meet plan benefit coverage criteria. The provider is responsible for documenting the medical necessity of services through the authorization process.

**13.4.2** **Benefit Coverage Determinations.** Benefit coverage determinations are made by the Health Plan's Support Clinicians based upon your benefit plan and may include an adverse determination due to a limitation in benefit coverage or an exclusion of benefit coverage. These are not medical necessity determinations.

**13.4.3** **Support Clinicians/Clinical Peer Reviewers.** All clinical reviews are conducted by licensed peer reviewers who meet the Health Plan provider credentialing process and possess the additional qualifications.

**13.4.4** **Member Disclosure**. The process used by Health Plan to authorize, modify, or deny health care services under any benefit plan will be disclosed to members or their designees upon request.

**13.4.5** **Notifications and Time Frames.** Unless specific state or federal law requires other time frame and notification standards, the following will apply for Health Plan's utilization management determinations.

**13.4.5.1** Health Plan uses one standard process that applies to both concurrent and retrospective review. The Support Clinician completes the concurrent review process within five (5) business days of receipt of all necessary information. Retrospective reviews are completed within thirty (30) business days of receipt of all necessary information.

**13.4.5.2** An Authorization Response is sent to the provider and Enrollee indicating the Support Clinician's decision within one (1) business day of the date of decision. The written response is sent to the provider by U.S. Mail. Written notification is sent to the Enrollee by U.S. Mail.

**13.4.5.3** The Authorization Response sent to the provider and the Enrollee includes messages addressing any changes to the requested treatment plan. In addition, each response to the provider includes

the name of the Support Clinician and instructions and timelines for the submission of missing or additional documentation.

**13.4.5.4** If Health Plan cannot make a decision to approve, modify or deny a request for authorization within the time frames specified above because Health Plan is not in receipt of all of the information reasonably necessary and requested, or because Health Plan requires consultation by an expert reviewer, or because Health Plan has asked that an additional examination or test be performed upon the member (provided the examination or test is reasonable and consistent with good medical practice in the organized chiropractic community), Health Plan shall, immediately upon the expiration of the specified time frame, or as soon as Health Plan becomes aware that it will not meet the time frame, whichever occurs first, notify the provider and the member, in writing, that Health Plan cannot make a decision to approve, modify, or deny the request for authorization within the required time frame, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. Health Plan shall also notify the provider and the member of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested, Health Plan will approve, modify, or deny the request for authorization within the applicable time frame specified above.

**13.4.5.5** A request for services may be denied on the basis that information necessary to determine medical necessity was not received. If Health Plan requests medical information from a provider in order to determine whether to approve, modify, or deny a request for authorization, Health Plan will request only the information reasonably necessary to make the determination. A reasonable attempt to obtain the missing information from the enrollee's provider will be made prior to denying services based on lack of information. The request for the necessary information will be handled in accordance with Health Plan policy.

**13.4.5.6** In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of Health Plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member.

**13.4.6 Adverse Determinations.** Unless specific state or federal law requires other time frame and notification standards, the following will apply for Health Plan's utilization management determinations.

**13.4.6.1** An adverse determination by a Health Plan Support Clinician means one or more of the service(s) requested was determined to be not Medically Necessary or appropriate.

**13.4.6.2** Clinical determinations are decisions made with regard to the provider's requested duration of care, quantity or services or types of services.

**13.4.7** Nothing in this Section 13 shall be construed or applied to interfere with a Member's right to submit a grievance or seek an independent medical review in accordance with applicable law. Members shall in all cases have an opportunity to submit a grievance to Health Plan or seek an independent medical review whenever a health care service is denied, modified, or delayed by Health Plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not Medically Necessary.

**13.4.8** All grievances shall be handled in accordance with Health Plan's Grievance Resolution Policies and Procedures, as described in Section 16.

**13.4.9** A request for an independent medical review shall be handled in accordance with Health Plan's policies and procedures on independent medical reviews or, if applicable, the policies and procedures on independent review of decisions regarding experimental or investigational therapies, as described in Section 16.5.

## SECTION 14. REIMBURSEMENT PROVISIONS

Members may receive Covered Services under the Group Enrollment Agreement only from Participating Providers or as directed by the Health Plan. Claims for reimbursement for Covered Services received by a Member shall be submitted by the Participating Provider. The Member shall not be responsible for submitting claim forms for reimbursement of any Covered Services.

# SECTION 15. RESPONSIBILITIES OF HEALTH PLAN

## 15.1 Arrangements for Covered Services

Health Plan will enter into arrangements with Participating Providers in order to make available to Members the Covered Services described in this document. Subject to Section 8.6, Health Plan makes no warranty or representation to the Group or to Members regarding the continued availability of any particular Participating Provider to a particular Member or to Members in general.

## 15.2 Compensation of Providers

Health Plan will be responsible for compensating Participating Providers for Covered Services provided to eligible Members in accordance with the requirements of any contract between Health Plan and the Participating Provider. As required by state law, all contracts between Health Plan and Participating Providers provide that, in the event Health Plan fails to pay the Participating Provider for Covered Services for which Health Plan is financially responsible, no Member shall be liable to the Participating Provider for Covered Services.

In the event that Health Plan fails to pay a provider who is not a Participating Provider for Covered Services for which Health Plan is financially responsible, the Member who received such services may be liable to the provider for the cost of the services.

## 15.3 Toll-Free Telephone Number

Health Plan will make available to Members a published toll-free telephone number to contact Health Plan. This telephone number is available to Members twenty-four hours a day, seven days a week.

## 15.4 Public Policy Committee

Health Plan's Public Policy Committee will participate in establishing public policy for Health Plan's chiropractic and acupuncture benefits programs including, but not limited to, the comfort, dignity and convenience of Members. Members are invited to participate in the Public Policy Committee and may write to the Chair of the Public Policy Committee at the address included on the cover of this document.

## 15.5 Notices to Group Representatives

Any notice given by Health Plan to the Group pursuant to the Group Enrollment Agreement may be given by Health Plan to the group representative designated by the Group pursuant to this Section 15.5.

## 15.6 Termination or Breach of a Participating Provider Contract

**15.6.1** Health Plan shall provide Group written notice within 30 days of Health Plan's receipt of any Participating Provider's notice of termination or inability to perform its contract with Health Plan, or within 30 days of Health Plan's providing to any Participating Provider a notice of termination or uncured breach, if the Group or any Member may be materially and adversely affected by such termination, breach, or inability to perform.

**15.6.2** In the event that a contract between Health Plan and a Participating Provider terminates while a Member is under the care of such Participating Provider, Health Plan will arrange for the provision of continuity of care services as described in Section 8.6.

**15.6.3** In the event that Health Plan fails to pay a non-contracting provider for any amounts owed by the Health Plan, Member may be responsible to the non-contacting provider for the cost of services.

# SECTION 16. GRIEVANCE PROCEDURES

## 16.1 Applicability of the Grievance Procedures

All Member disputes and controversies arising under the Plan will be resolved pursuant to the Grievance Procedures set forth in this Section 16.

## 16.2 Grievances

Every Member has the right to communicate a grievance to Health Plan by calling the telephone number listed below, by submitting a written grievance to the address indicated below, by submitting a written grievance by facsimile or email, or by completing an online grievance form.

Grievance Coordinator
OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009
1-800-428-6337
(619) 641-7185 (Fax)
www.myoptumhealthphysicalhealthofca.com

Health Plan will acknowledge receipt of the grievance in writing for urgent issues on the day of receipt, and all routine grievances within five (5) calendar days of receipt. These deadlines do not apply to grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day.

If the grievance pertains to a Quality of Service issue, it may be investigated and resolved by the Health Plan in collaboration with any other involved departments. If the grievance pertains to a Quality of Care issue and is routine, the Health Plan transfers the information to the Medical Director. If the grievance pertains to a Quality of Care issue and is urgent, the Health Plan will promptly initiate the Expedited Review process.

Health Plan will provide a written statement on the determination of any grievance except for grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day. For an urgent grievance in which medical/clinical services are underway, Health Plan will notify the complainant and the Department within twenty-four (24) hours of the Health Plan's receipt of the grievance. For all other urgent grievances, Health Plan will notify the complainant and the Department within three (3) calendar days of the Health Plan's receipt of the grievance. For routine grievances, Health Plan will notify the complainant within five (5) calendar days of the Health Plan's receipt of the grievance.

Grievance forms and Health Plan’s grievance policies and procedures are available to Members upon request.

## 16.3 Expedited Review of Grievances

For Member grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, Health Plan shall immediately inform the Member, in writing, of the Member's right to notify the Department, and to provide the Member and the Department written notice of the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the grievances.

## 16.4 Independent Medical Review

In the event the Member is dissatisfied with the findings and decision of Health Plan, the Member is not required to further participate in Health Plan’s grievance process thirty (30) days after Health Plan’s receipt of the complaint. The Member may request an Independent Medical Review (IMR) of Disputed Health Care Services from the Department if the Member believes that health care services have been improperly denied, modified, or delayed by the Health Plan or one of its contracting providers. A “Disputed Health Care Service” is any health care service eligible for coverage and payment under

the subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to the Member. The Member pays no application or processing fees of any kind for IMR. The Member has the right to provide information in support of the request for IMR. The Plan must provide the Member with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against the plan regarding the Disputed Health Care Service.

For more information regarding the IMR process, or to request an application form, please call Health Plan's Customer Services department at 1-800-428-6337; or write to OptumHealth Physical Health of California at P.O. Box 880009, San Diego, CA
92168-0009.

## 16.5 IMR for Experimental and Investigational Therapies

You may also have the right to an independent medical review through the Department if the Health Plan denies coverage for a requested service on the basis that it is experimental or investigational. Health Plan will notify you within 5 business days of its decision to deny an experimental/investigational therapy. You are not required to participate in the Health Plan's grievance process prior to seeking an independent medical review of this decision.

The Independent Medical Review Organization will complete its review within 30 days of receipt of your application and supporting documentation. If your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the review will be completed within 7 days.

## 16.6 Implementation of IMR Decision

If the Member receives a decision by the Director of the Department that a Disputed Health Care Service is Medically Necessary, Health Plan will promptly implement the decision.

In the case of reimbursement for services already provided, Health Plan will reimburse the provider or Member within five (5) working days. In the case of services not yet provided, Health Plan will authorize the services within five (5) working days of receipt of the written decision from the Director or sooner, if appropriate for the nature of the Member's medical condition, and will inform the Member and Provider of the authorization according to the requirements of Health and Safety Code Section 1367.01(h)(3).

## 16.7 Exhaustion of Remedies

A Member shall not be entitled to maintain a cause of action alleging that Health Plan has failed to exercise ordinary care unless the Member or his or her representative has exhausted the procedures provided by IMR process, except in a case where either of the following applies: (i) substantial harm has occurred prior to the completion of the IMR process; or (ii) substantial harm will imminently occur prior to the completion of the IMR process. For purposes of this Section 16.7, substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.

## 16.8 Department Review

**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 (1-800-428-6337) or (1-619-641-7100) or for TTY/TDD services call 1-(888) 877-5379 (voice), or 1-(888) 877-5378 (TDDY)) and use your health plan's grievance process before contacting the Department. 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 has remained unresolved for more than 30 days, you may call the Department 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) or (1-800-735-2929) for the hearing- and speech-impaired. The Department's Internet website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.**

# SECTION 17. TERMINATION OF BENEFITS

## 17.1 Basis for Termination of a Member's Coverage

Health Plan may terminate a Member's coverage for any one or more of the following reasons:

**17.1.1** If the Group has failed to pay a premium due within 31 days of the Premium Due Date, Health Plan shall send a notice of cancellation to the Group requesting payment of any past due premiums and providing notice that coverage for a Member whose premium is unpaid shall terminate automatically as of the sixteenth (16th) day following issuance of such notice of cancellation. If the Member is hospitalized or undergoing treatment for an ongoing condition at the time of such termination, Health Plan shall continue to be financially responsible only for those Chiropractic Services and Acupuncture Services provided after such termination that had already received prior written certification as Covered Services, and had already commenced, as of the date of such termination.

**17.1.2** The Member fails to pay or make appropriate arrangements to pay a required Copayment after the Member has been billed by the provider for two different billing cycles. Health Plan will provide the Member with written notice, and the Member will be subject to termination if payment or appropriate payment arrangements are not made within the thirty (30)-day notice period.

**17.1.3** If the Member permits the misuse of his or her identification documents by any other person, or misuses another person's identification, coverage of the Member may be terminated immediately upon notice to the Member. The Member shall be liable to Health Plan for all costs incurred as a result of any misuse of identification documents.

**17.1.4** A Member's coverage will be terminated upon mailing of notice if a Member threatens the safety of any provider, his or her office staff, or the Health Plan if such behavior does not arise from a diagnosed illness or condition. In addition, a Member's coverage may be immediately terminated upon mailing of notice if the Member repeatedly or materially disrupt the operations of the Health Plan to the extent that the Member's behavior substantially impairs Health Plan's ability to furnish or arrange services for the Member or other Members or substantially impairs the ability of any provider, or his or her office staff, to provide services to other patients.

**17.1.5** The Member moves out of the service area without the intention to return. Termination shall be effective on the sixteenth (16th) day following issuance of such notice.

**17.1.6** The Member voluntarily disenrolls, provided the Group allows voluntary disenrollment. Termination shall take effect on the last day of the month in which the Member voluntarily disenrolls.

**17.1.7** The notice of cancellation issued by Health Plan shall be in writing and dated, and shall state:

(A) The cause for cancellation, with specific reference to the clause of this Agreement giving rise to the right of cancellation;

(B) That the cause for cancellation was not the Member's health status or requirements for health care services;

(C) The time when the cancellation is effective; and

(D) That a Member who alleges that an enrollment or subscription has been cancelled or not renewed because of the Member's health status or requirements for health care services may request a review of cancellation by the Director of the Department.

## 17.2 Reinstatement

Subject to Section 17.5, the reinstatement of any Member whose coverage under this Agreement has terminated for any reason shall be within the sole discretion of Health Plan. This Section does not apply to reinstatement of the Group, but

rather to reinstatement of a Member whose coverage has terminated for reasons unrelated to cancellation of the Group Enrollment Agreement for nonpayment.

## 17.3 Rescission

If, at any time, Health Plan determines that a Member fraudulently or intentionally provided incomplete or incorrect material information and Health Plan's decision to accept the Member's enrollment was based, in whole or in part, on the misinformation, Health Plan may rescind the Member's membership instead of terminating the Member's coverage upon the date of mailing. Rescind means Health Plan will completely cancel membership so that no coverage ever existed. Health Plan can also rescind membership if it finds that a Member fraudulently or intentionally did not inform Health Plan about changes to the information the Member submitted in their enrollment application that occurred before the Member's coverage became effective, and Health Plan would have denied the Member's enrollment if the Member had informed Health Plan about the changes. If Health Plan rescinds a membership, Health Plan will send written notice to the affected Member which will explain the basis for Health Plan's decision and how the Member may appeal the decision. Any Member whose membership is rescinded will be required to pay as a non-Member for any services Health Plan covered. Within 30 days, Health Plan will refund all applicable premiums amounts due pursuant to Section 17.4, except that Health may subtract any amounts the Member owes Health Plan. The Member will not be allowed to enroll in an OptumHealth Physical Health of California health plan in the future.

## 17.4 Return of Premiums for Unexpired Period

In the event of termination or rescission of a Member's coverage by Health Plan, Health Plan shall, within thirty (30) days following such termination, return to the Group the pro rata portion of any premium paid to Health Plan that corresponds to any unexpired period for which payment had been made less any amounts due to Health Plan from the Group.

## 17.5 Director Review of Termination

Any Member who in good faith believes that his or her coverage has been terminated or not renewed because of the Member's health status or requirements for Chiropractic Services or Acupuncture Services, may request a review of the termination or non-renewal by the Director of the California Department of Managed Health Care. If the Director determines that a proper complaint exists under Section 1365 of the California Health and Safety Code, the Director will notify Health Plan of that fact. Health Plan must, within fifteen (15) days after receipt of the notice, either request a hearing or reinstate the Member. If, based on the hearing, the Director determines that the termination or non-renewal is contrary to applicable law; Health Plan must reinstate the Member retroactive to the time of the termination or non-renewal. Under such circumstances, Health Plan will be liable for the expenses incurred by the Member after the termination or non-renewal for Chiropractic Services or Acupuncture Services that would otherwise have received certification as Covered Services.

## 17.6 Individual Continuation of Benefits

In the event the Group ceases to exist, the Group contract is terminated, an individual Subscriber leaves the Group or the Member's eligibility status changes, the Member may remain in the Plan if he or she otherwise satisfies the eligibility criteria for COBRA.

### 17.6.1 Continuation of Benefits for Totally Disabled Members

If a Member becomes Totally Disabled while covered under the Group Enrollment Agreement, and the Group Enrollment Agreement between Health Plan and the Group is subsequently terminated, benefits for Covered Services directly relating to the disabling condition will continue for twelve (12) months following the last day of coverage for which a total monthly premium was paid to Health Plan on behalf of the Member, notwithstanding the termination of the Group Enrollment Agreement during such period. Any extension of benefits may be terminated at such time as the Member is no longer totally disabled or at such time as coverage for the Member becomes effective under any replacement agreement or policy. Covered Services provided after termination will be subject to all of the Exclusions and Limitations, as well as all of the other terms and conditions, contained in this document, including, but not limited to, all applicable Copayments and Annual Benefit Maximums. A Member who is not a Family Dependent will be considered to be Totally

Disabled when as a result of bodily injury or disease, he or she is prevented from engaging in any occupation for compensation or profit; a Member who is a Family Dependent will be considered totally disabled when such Member is prevented from performing all regular and customary activities usual for a person of his or her age and family status. An enrolled Family Dependents who attain the limiting age may continue enrollment in the Health Plan beyond the limiting age if the Family Dependent meets all of the following:

1. The Family Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. The Family Dependent is chiefly dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Family Dependent reaching the limiting age, you, the Subscriber will receive notice that coverage for the disabled Family Dependent, will terminate at the end of the limiting age unless proof of such incapacity and dependency is provided to Health Plan by the Member within 60 days of receipt of notice. Health Plan shall determine if the disabled Family Dependent meets the conditions above, prior to the disabled Family Dependent reaching the limiting age. Otherwise, coverage will continue until Health Plan makes a determination.

Health Plan may require ongoing proof of a Family Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Family Dependent's attainment of the limiting age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other physician to the effect that such disabled Family Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, Health Plan may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide Health Plan with the requested information within 60 days of receipt of the request. The child must have been covered as a dependent of the Subscriber or spouse under a previous health plan at the time the child reached the age limit.

### 17.6.2 Continuation of Coverage under Federal Law

If Member's coverage ends, Member may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law. Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Groups that are subject to the terms of COBRA. Member can contact his or her plan administrator to determine if the Group is subject to the provisions of COBRA. If Member selected continuation coverage under a prior plan which was then replaced by coverage under this plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier. Health Plan is not the Group's designated "plan administrator" as that term is used in federal law and does not assume any responsibilities of a "plan administrator" according to federal law.

Health Plan is not obligated to provide continuation coverage to Member if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are: (A) Notifying Member in a timely manner of the right to elect continuation coverage; and (B) Notifying Health Plan in a timely manner of your election of continuation coverage.

### 17.6.3 Qualified Beneficiary

In order to be eligible for continuation coverage under federal law, Member must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who was covered under the plan on the day before a qualifying event:

(A) A Subscriber.

(B) A Subscriber's Family Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

(C) A Subscriber's former spouse.

**17.6.3.1 Qualifying Events for Continuation Coverage under Federal Law (COBRA)**

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

(A) Termination of the Subscriber from employment with the Group, for any reason other than gross misconduct, or reduction of hours; or

(B) Death of the Subscriber;

(C) Divorce or legal separation of the Subscriber;

(D) Loss of eligibility by a Family Dependent who is a child;

(E) Entitlement of the Subscriber to Medicare benefits; or

(F) The Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Family Dependents. This is also a qualifying event for any retired Subscriber and his or her Family Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

**17.6.4 Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)**

The Subscriber or other Qualified Beneficiary must notify the Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or a Family Dependent's loss of eligibility as a Family Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period, the Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Group's designated plan administrator. If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

**17.6.5 Terminating Events for Continuation Coverage under Federal Law (COBRA)**

Continuation under this document will end on the earliest of the following dates:

(A) Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A). If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A, then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the

required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

(B) Thirty-six months from the date of the qualifying event for a Family Dependent whose coverage ended because of the death of the Member, divorce or legal separation of the Subscriber, loss of eligibility by a Family Dependent who is a child (i.e., qualifying events B, C, or D).

(C) For the Family Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

(D) The date coverage terminates under the plan for failure to make timely payment of the Premium.

(E) The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

(F) The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Group filed for bankruptcy, (i.e., qualifying event F)

(G) The date this document terminates.

(H) The date coverage would otherwise terminate under this document.

**17.6.5 CAL-COBRA.**

Group with two (2) to nineteen (19) subscribers who do not qualify for federal COBRA, continuation coverage under this Health Plan shall comply with the requirements of the California Continuation Benefits Replacement Act, as amended ("Cal-COBRA"). Continuation coverage under Cal-COBRA shall be provided in accordance with section 1366.20 et seq. of the California Health and Safety Code, and shall be equal to, and subject to the same limitations as, the benefits provided to other Group Members regularly enrolled in this Health Plan. Group shall provide affected Members with written notice of available continuation coverage as required by, and in accordance with, Cal-COBRA and amendments thereto.

**17.6.5.1 Notice Upon Termination.**

Upon the termination of continuation coverage under Cal-COBRA, Group shall notify affected Members receiving Cal-COBRA continuation coverage whose continuation coverage will terminate under Health Plan prior to the end of statutory continuation coverage period of the Member's ability to continue coverage under a new group plan for the balance of the statutory period. Notice shall be provided 30 days prior to the termination or when all Members are notified, whichever is later Group shall notify a successor plan in writing of the Members receiving Cal-COBRA continuation coverage.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage

ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Group filed for bankruptcy, (i.e., qualifying event F) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Group's designated plan administrator for information regarding the continuation period.

# SECTION 18. GENERAL INFORMATION

## 18.1 Relationship Between Health Plan and Each Participating Provider

The relationship between Health Plan and each Participating Provider is an independent contractor relationship. Participating Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an employee or agent of any Participating Provider. Health Plan will not be liable for any claims or demands on account of damages arising out of, or in any manner connected with, any injury suffered by a Member relating to Chiropractic Services or Acupuncture Services received by the Member from any Participating Provider.

## 18.2 Members Bound by the Group Enrollment Agreement

By the Group Enrollment Agreement, the Group makes coverage under Health Plan's chiropractic and acupuncture benefits program available to Members who are eligible and duly enrolled in accordance with the requirements of the Group Enrollment Agreement. The Group Enrollment Agreement is subject to amendment and termination in accordance with its terms without the necessity of either Health Plan or the Group obtaining the consent or concurrence of any Member. By electing coverage or accepting benefits under the Group Enrollment Agreement, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to be bound by all of the terms and conditions of the Group Enrollment Agreement. In the case of conflicts between the Group Enrollment Agreement and this *Combined Evidence Of Coverage and Disclosure Form*, the provisions of this *Combined Evidence Of Coverage and Disclosure Form* shall be binding upon Health Plan notwithstanding any provisions of the Group Agreement that may be less favorable to Members.

## 18.3 Nondisclosure and Confidentiality

Neither Health Plan nor the Group shall release any information regarding the terms set forth in this Agreement to any person or entity without the prior written consent of the other, except such information as may be necessary to disclose to agents, affiliates, attorneys, accountants, governmental regulatory agencies, non-covered custodial parents of a covered children, or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law or provisions of the Agreement, Health Plan and the Group shall keep confidential, and shall take the usual precautions to prevent the unauthorized disclosure of any and all resources required to be prepared or maintained in accordance with this Agreement.

## 18.4 Overpayments

Member shall agree to reimburse Health Plan, on demand, any and all such amounts Health Plan pays to or on behalf of a Member:

(A) For services or accommodations which do not qualify as Covered Services;

(B) With respect to a Subscriber's family member or a person believed to be a Subscriber's family member, who is not entitled to Covered Services under the Group Enrollment Agreement; or

(C) Which exceeds the amounts to which the Member is entitled under the Group Enrollment Agreement.

## 18.5 Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

## 18.6 Interpretation of Benefits

Subject to the Member grievance procedures specified in Section 16, Health Plan has the sole and exclusive discretion to do all of the following:

(A) Interpret benefits under the plan.

(B) Interpret the other terms, conditions, limitations and exclusions set out in the plan, including this document and any Amendments.

(C) Make factual determinations related to this document and benefits.

Health Plan may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Health Plan may, in its sole discretion, offer benefits for services that would otherwise not be Covered Services. The fact that Health Plan does so in any particular case shall not in any way be deemed to require Health Plan to do so in other similar cases.

## 18.7 Administrative Services

Health Plan may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Health Plan's sole discretion. Health Plan is not required to give Member prior notice of any such change, nor is Health Plan required to obtain Member's approval. Member must cooperate with those persons or entities in the performance of their responsibilities.

## 18.8 Amendments to the Plan

To the extent permitted by law, Health Plan reserves the right, in Health Plan's sole discretion and without Member's approval, to change, interpret, modify, withdraw or add benefits or terminate this document. Any provision of this document which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations, (of the jurisdiction in which this document is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations. No other change may be made to this document unless it is made by an Amendment, which has been signed by one of Health Plan's officers. All of the following conditions apply:

(A) Amendments to this document are effective 31 days after Health Plan sends written notice to the Group.

(B) Riders are effective on the date Health Plan specifies.

(C) No agent has the authority to change this document or to waive any of its provisions.

(D) No one has authority to make any oral changes or amendments to this document.

## 18.9 Clerical Error

If a clerical error or other mistake occurs, that error will not deprive Member of benefits under this document, nor will it create a right to benefits. If the Group makes a clerical error (including, but not limited to, sending Health Plan inaccurate information regarding Member's enrollment for coverage or the termination of Member's coverage under the this document) Health Plan will not make retroactive adjustments beyond a 60-day time period.

## 18.10 Information and Records

At times, Health Plan may need additional information from Member. Member agrees to furnish Health Plan with all information and proofs that Health Plan may reasonably require regarding any matters pertaining to this document. If Member does not provide this information when Health Plan requests it, Health Plan may delay or deny payment of Member's benefits. By accepting benefits under this document, Member authorizes and directs any person or institution that has provided services to Member to furnish Health Plan with all information or copies of records relating to the services provided to Member. Health Plan has the right to request this information at any reasonable time. Health Plan agrees that such information and records will be considered confidential. Health Plan has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this document, for appropriate medical review or quality assessment, or as Health Plan is required to do by law or regulation. During and after the term of this document, Health Plan and our related entities may use and transfer the information gathered under this document in a de-identified format for commercial purposes, including research and analytic purposes. For complete listings of your medical records or billing statements Health Plan recommends that Member contact his or her health care provider. Providers may charge Member reasonable fees to cover their costs for providing records or completing requested forms. If Member requests forms or records from us, Health Plan also may charge Member reasonable fees to cover costs for completing the forms or providing the records. In some cases, Health Plan will designate other persons or entities to request

records or information from or related to Member, and to release those records as necessary. Health Plan's designees have the same rights to this information as Health Plan has.

## 18.11 Preventive Health Information

Health Plan has preventive health information on its websites, **www.myoptumhealthphysicalhealthofca.com** and **www.myoptumhealth.com**. The information is presented to educate members on prevention of musculoskeletal injuries or conditions. The information is not intended to replace the advice received from your medical care provider. Any information taken from the website should be discussed with your medical provider to determine whether it is appropriate for your condition.

**Website Address:**
**http://www.myoptumhealthphysicalhealthofca.com**

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

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