alameda county
Human Resource Services
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2026 EMPLOYEE BENEFITS HANDBOOK

USING THIS HANDBOOK

This is a "navigable" PDF.

- Click on any topic in the Table of Contents to access the page you're looking for.
- Click on the TOC icon on the top of each page to return to the Table of Contents.
- Use the Adobe Acrobat forward and backward arrows to navigate this document.

Please refer to this handbook whenever you need information about Alameda County benefits.

However, if this information does not address all of your specific questions, please contact the EMPLOYEE BENEFITS CENTER, which maintains comprehensive information for all of our benefit programs.

CONTACT US

EMPLOYEE BENEFITS CENTER

1405 Lakeside Drive
Oakland, CA 94612

8:00 a.m. to 5:00 p.m., Monday – Friday

Call the EBC at 510.891.8991
8:00a.m. to 4:30p.m., Monday – Friday

emailEBC@acgov.org

Benefits Enrollment Assistant (BEA) Chatbot : https://ebc-chatbot.acgov.org

Visit EBC Online: https://hrs.alamedacountyca.gov/employee-benefits-center/

The benefit plan descriptions in this document are summaries only.

The benefits highlighted here are governed by the plan contracts and policies, and applicable state and federal laws. If there is a conflict between the wording of this document and the group policies and contracts, the policies, contracts and applicable laws govern.

The County of Alameda reserves the right to alter, amend or terminate any of the benefits described in this summary at any time.

Specific information is located in the Evidence of Coverage (EOC) for each plan and other materials on the County's website and employee Benefits Center online.

The County is considered the Plan Administrator and has discretionary authority to administer and interpret the Plan* and may delegate this authority and any duties it deems appropriate to facilitate administration of the Plan.

Each insurance company and/or claims administrator may, in its discretion, interpret and apply the terms of their plan with regard to benefit payments and make findings of fact. This includes determining if an individual is entitled to benefits and calculating benefit payments. Any determination made by the Plan Administrator (or any entity acting on behalf of the Administrator) is final and binding.

By adopting and maintaining these Plans, Alameda County has not entered into an employment contract with any employee.

***The Plan means all benefit plans offered by the County of Alameda.**

ALAMEDA COUNTY

TABLE OF CONTENTS

ALAMEDA COUNTY

TABLE OF CONTENTS

INTRODUCTION

This Handbook provides a summary of all the benefits provided to you as an employee of Alameda County. These benefit programs bring considerable value to you. In addition to a competitive salary, the County offers a wide variety of benefits to provide healthcare and other assistance for you and your family, including:

- Medical insurance
- Dental insurance
- Vision care
- Life and Disability insurance
- Share-the-Savings
- Flexible Spending Accounts
- Retirement programs, and
- Other benefits options to meet your needs

For some benefits, the County pays the entire cost of your coverage. For others, you may contribute all or a portion of the cost of coverage. Contribution amounts vary according to the plan you select, number of dependents you enroll, your representation unit, and the level of coverage you select. In most cases, your contribution will be deducted from your semi-monthly paycheck on a pre-tax basis.

How to use this Handbook

This Handbook provides information on all the benefit plans available to you, your costs and how the plans work. As an important part of this Handbook, the Appendix includes specifics on plan benefits provided by the insurance carriers (called Evidence of Coverage, or EOC), contact information for all plan vendors, and more.

We encourage you to familiarize yourself with this Handbook as your first resource for benefits information. If you cannot find an answer to your specific question, please feel free to contact the employee Benefits Center (EBC) for guidance.

Hours: 8:00 a.m. to 5:00 p.m.

By phone: (510) 891-8991

By email: emailEBC@acgov.org

By Chatbot: https://ebc-chatbot.acgov.org

To access a BENEFITS OVERVIEW video, scan the QR code.
CLICK HERE

Generally, all full-time and part-time employees are eligible for County benefits. Your eligibility for specific levels of coverage is determined by your classification, standard hours, Memorandum of Understanding, Salary Ordinance and/or the Administrative Code. If you are unsure of your eligibility, contact the Employee Benefits Center.

Full-Time Employee

You are considered a full-time employee if your standard hours are either 80 hours or 75 hours every two weeks, depending on your classification.

Part-Time Employee

You are considered a part-time employee if your standard hours are less than 80 hours or 75 hours every two weeks, depending on your classification. To be eligible for benefits your scheduled hours must be 50% of your Job Code standard hours.

When to Enroll

If you are hired into a benefits-eligible position, you will be given a New Hire Packet and instructions during your new hire orientation. If you become eligible at a later time, the Employee Benefits Center will provide you with an enrollment package and instructions.

You are responsible for completing all benefits enrollment procedures by the stated deadline or you will not be covered. If you fail to enroll by the deadline, your next opportunity to enroll in benefits will be during the annual Open Enrollment period in October/November. In that case, benefits start on February first of the following year – the start of the County's new benefit plan year.

Who You Can Enroll

If you are eligible, you may choose to enroll your eligible dependents in the same plans you enroll yourself. Your eligible dependents generally include:

Spouse

Your legal spouse is eligible for benefits when you enroll yourself. Contributions toward your spouse's coverage are taken from your paycheck on a pre-tax basis.

NOTE: You cannot cover an ex-spouse on our plans, even with a court order.

Domestic Partner

To cover a domestic partner, your partner must meet the County's domestic partner criteria found in the **Dependent Certification Documentation** section on the following page.

If your domestic partner qualifies, you may also cover your partner's children, as long as they meet the same qualifications as stated under **Your Children or Young Adult Dependents**.

Your contribution towards domestic partner coverage is on an after-tax basis unless your domestic partner qualifies as your "tax dependent." The County's portion of the cost is considered taxable income by the IRS.

If you and your domestic partner are "registered domestic partners" under California law, the cost of your benefits are not subject to California tax.

Children

Your children up to age 26 include:

- Your biological children
- Stepchildren
- Adopted children
- Children placed with you for adoption
- Children for whom you have legal guardianship
- Children listed under terms of a Qualified Medical Child Support Order (QMCSO)

Your children also include dependents of any age with a mental or physical disability as long as the dependent:

- Is currently covered under the plan and became disabled prior to reaching age 26,
- Is incapable of self-sustaining employment as a result of that disability, and
- Is financially dependent on you.

Young Adult Dependents

Your young adult dependents up to age 26 are considered your dependents as defined above. Eligibility for other coverage, marital status, student status and place of residence do not impact eligibility for benefits with the County.

Proof of Dependent Eligibility

Any time you enroll a dependent, the County requires you to certify (or, provide proof) that your dependent(s) meet the eligibility requirements. This section describes the documentation process and what the County considers appropriate proof of dependent eligibility.

Documentation Certification Process

If you are newly eligible for benefits or add a new dependent due to a qualifying event (see next page for definition), you must submit supporting documentation with your paper enrollment form. By signing the paper enrollment form, you certify your supporting documentation is true and accurate.

For new hire enrollment or during the annual Open Enrollment period, when you submit your enrollment through eBenefits, you certify that your existing dependents meet the County's definition of dependent eligibility. However, if you add a new dependent during your new hire enrollment or during Open Enrollment you must submit supporting documentation with a Documentation Certification Form to the EBC by the end of the new hire enrollment or Open Enrollment period.

In any case, the employee name and ID number must be written on each page of the supporting documentation so it can be clearly identified to whom it belongs. If the required documentation is not submitted to the EBC by the communicated deadline, your dependents will not be added to the benefit coverage(s) you elect.

Dependent Certification Documentation

If you are adding a dependent who meets the eligibility criteria stated on page 6, you must provide the EBC with the following supporting documentation before the end of your enrollment period:

- **For a Spouse.** Original or photocopy of your certified Marriage Certificate.
- **For a Domestic Partner.** The County's Domestic Partner Affidavit Form (available on request from the EBC or online at **https://hrs.alamedacountyca.gov/employee-benefits-center/**). Or, you can use the California State Affidavit.
- **For Dependent Children up to Age 26.** A copy of the child's certified Birth Certificate with you and/or your spouse or your domestic partner registered as parent(s), or court-filed guardianship/adoption papers with the presiding judge's signature and seal.
- **For Disabled Children.** A copy of the child's Birth Certificate with you and/or your spouse or your domestic partner registered as parent(s), or court-filed guardianship/adoption papers with the presiding judge's signature and seal. If your currently covered child reaches age 26, a certification from a physician will be required.

PLEASE NOTE: If you are adding coverage for a new or newly eligible dependent during the annual Open Enrollment period, the Documentation Certification Form is required. Please ensure that your **name and Employee ID** are written on all of the supporting documentation you submit along with the Documentation Certification Form to the EBC so we can identify to whom it belongs.

Covered Under Another Plan?

If you are covered under another medical plan, you can waive medical coverage through the County and receive a monthly stipend through **Share-the-Savings** (see Share-the-Savings for details).

When Your Spouse/Domestic Partner Also Works for the County

If you and your spouse/domestic partner both work for the County, you can only enroll in a medical plan as an employee or as a spouse/domestic partner, but not both. You can enroll yourself as an employee or you can be covered as a dependent under your spouse's plan. If you are enrolled in more than one plan, coverage will be terminated with no refund of premium contributions. The county will not allow duplicate coverage under the same plan.

Under certain circumstances, you may change some of your benefits elections outside the Open Enrollment period. To make a change, you must experience a **qualifying event** or a **change in status** as defined by the Internal Revenue Code, Section 125. To make a change, contact the EBC to request a paper enrollment form. These forms need to be completed and submitted with the appropriate documentation (discussed on page 7) within the specified time period for a qualifying event.

As the employee, it is your responsibility to contact the EBC when you experience a qualifying event within the applicable 30-day or 60-day timeframes outlined below. If you do not notify the EBC within the specified timeframe, you will not be able to change your coverage until the next Open Enrollment period, or you may lose eligibility for some coverage.

Within 30 Days of these Qualifying Events

- Marriage/Domestic partnership
- Birth or adoption of a child
- Return from a leave of absence
- Relocation by you or your enrolled dependent outside of the medical plan's service area
- Your dependent's death
- Your dependent child gains eligibility under the plan due to loss of other coverage
- A change in your or your dependent's own employment status that impacts your eligibility for benefits
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires health coverage for your dependent child
- Loss of alternate medical or dental coverage

Within 60 Days of these COBRA-Qualifying Events*

- Divorce, legal separation, termination of domestic partnership
- Loss of your Child's dependent status under the Plan due to age
- You or your dependent becomes eligible for Medicare or COBRA coverage under this plan

*COBRA is a Federal regulation that provides extension of County sponsored medical coverage for a fixed period after one of these qualifying events. For example, if your dependent child turns age 26, that dependent child will be dropped from your coverage and can apply for coverage under COBRA. Coverage under COBRA is paid by the enrollee. See **COBRA** for details

Benefits that can be Added at any Time

The County provides some optional benefits that you can add or change at any time during the year. They include:

- Commuter Benefit Plan
- Group Home and Auto Insurance
- Group Pet Insurance

The County provides all eligible employees with a choice of three medical options from a variety of Health Maintenance Organization (HMO) plans to our Preferred Provider Organization (PPO). All plans cover medical expenses incurred for non-occupational illness or accidental injury. Coverage also includes mental health and substance abuse services, skilled nursing and more.

When you choose from among our five medical plan options, you can enroll your eligible dependents in the same plan.

- Kaiser Permanente Traditional HMO – with $15 or $40 copayment
- UnitedHealthcare's SignatureValue HMO – with $15 or $40 copayment
- UnitedHealthcare Select Plus PPO

When Coverage Starts

Deductions for your medical plan are on a semi-monthly basis. Your coverage starts the first of the month following two payroll deductions in a single month. For example:

- You are hired on **January 2**
- First payroll deductions are taken from your two paychecks in **February**
- Medical coverage starts **March 1**

Your Cost

When you work full-time hours, your semi-monthly contribution amount for medical coverage depends on the plan you select, the number of family members you cover and your bargaining status. This chart shows how you and the County share the cost of your medical coverage.

Bargaining Group	Your 2026 Contribution	County 2026 Contibution	to see actual cost, go to:
• SEIU • Unrepresented Non-Management	12%	88%	Appendix D
• ACCA • ACMEA DA Inspectors • ACMEA General & Confidential • ACMEA Probation Management • ACMEA Sheriff's Non-Sworn • ACMEA Sheriff's Sworn • ACPA • ACWFIA • BTC • CEMU • DSA • IFPTE (016, 060, 077) • PACE • PPOA • Public Defender Chapter • Teamsters • UAPD • Unrepresented Management	15%	85%	Appendix D

NOTE: If you work fewer than the full-time hours in a given pay period, the County contribution may be reduced.
See page 62 for details

How the HMO Plans Work

When you enroll in an HMO, there is no deductible to meet before you can receive benefits and, in most cases, no claim forms to complete. You are responsible for a copayment for most services. A list of those services and your copayment amount can be found in Appendix H. In addition, you must get all your care through the HMO's network of doctors and other health care professionals, hospitals, care facilities, labs, and pharmacies contracted with the plan you select.

If you enroll in Kaiser Permanente, all services are provided at a Kaiser facility and all the health care professionals are Kaiser employees.

If you enroll in UnitedHealthcare (UHC) you must select a Primary Care Physician (PCP) from a medical group that is contracted with UHC and get coverage through that group. For example, Hill Physicians is one of a number of medical groups contracted with UHC.

BE AWARE: If you receive services from a physician, hospital, pharmacy or other health care provider not contracted with your plan, or you receive services that have not been pre-approved by the plan or medical group, **you will be responsible for paying the bill in full.**

Primary Care Physician

A Primary Care Physician (PCP) coordinates all your care. Your PCP diagnoses and treats most of your illnesses and injuries; and is responsible for referring you to specialists and for needed laboratory tests, x-rays, and hospital care.

When you enroll, you may designate the same or a different PCP for each family member. Kaiser does not require a PCP, but generally recommends you select one. UnitedHealthcare requires that you have a PCP. If you do not choose a PCP when you enroll in the plan, UHC will assign one to you.

PCP's are often restricted to referrals within their own medical group. If access to a specific specialist or hospital is important to you, ask your potential PCP if he/she is affiliated with that specialist or hospital before making a PCP decision.

You may change your PCP for any reason during the year by contacting your plan member services. When the change becomes effective depends on when during the month you make the change. For example, you decide to change your PCP in March:

- Between 3/1 and 3/15 – Effective date is April 1
- Between 3/16 and 3/31 – Effective date is May 1

To find a PCP, your best resource is the HMO's website where you can search for providers by name, area and/or specialty.

Living Outside the HMO Service Area

Service area limits may apply for the UHC HMO and Kaiser Permanente. This means you must live in a zip code serviced by the plan. Please contact the medical plan to see if service is available to you.

Kaiser Permanente Partnership with CVS Minute Clinic

Kaiser Permanente members can visit the nearest MinuteClinic and pay their standard coinsurance or copay if they get sick or injured while traveling in a state **where Kaiser Permanente does not operate.** All that is needed is a photo ID and their membership card or health/medical record number.

Minute Clinics are located in select CVS Pharmacy and Target locations. They are staffed by non-Kaiser Permanente nurse practitioners and physician assistants who can treat a range of simple urgent care services for conditions and symptoms. Members can visit a MinuteClinic with or without an appointment. The MinuteClinic gives Kaiser Permanente members one more convenient alternative for urgent (non-emergency) care, including: Away from Home Travel Line (951-268-3900), **kp.org/travel**, and early refill of eligible prescriptions.

Pre-Certification

Certain medical services or treatment require the approval of your PCP or the plan before receiving services. This is also called pre-authorization or pre-approval.

Emergency Care

All HMO's provide coverage if you are out-of-area and have a medical emergency. Be sure you or a family member contacts your plan's Member Service as soon as possible for guidance on how to file a claim.

Filing Claims

These HMO's do not require a claim form to receive benefits, except for emergency care out-of-area. If you do not agree with how the plan handled your claim, you may file an appeal directly with the HMO.

How the PPO Plan Works

When you enroll in the PPO plan, you must meet a deductible before the plan begins to pay for most services. Some services, such as doctor visits and prescription drugs, have a copay that is not subject to the deductible. When enrolled in the PPO, there are no restrictions on what doctors and facilities you can visit, but providers that are not contracted as in-network will incur higher cost sharing.

What you Pay

- Premium Contributions – The semi-monthly amount you pay for your coverage through payroll deductions.
- Deductible – The HMO plans do not have a deductible. If you select the UnitedHealthcare Select Plus PPO, you will be required to meet a deductible before the plan starts to pay for certain services. Most doctor visits and prescription drugs require copays that are not subject to the deductible.
- Copayment – The dollar amount you pay when you receive care. In most cases this includes, but is not limited to office visits, prescriptions and hospital stays. Also called a copay.
- Coinsurance – If you are in the PPO plan, you will pay only a portion of costs once your deductible is met.
- Lifetime Maximum Benefits – These plans have no limit on the amount of benefits you may receive for most services.
- Annual out-of-pocket limit – Once your copayments or coinsurance reach a specific dollar amount, you are not responsible for any further copayments or coinsurance for the remainder of that year. Copayments for certain services do not count toward this annual limit.
- Non-covered charges – If you receive services or see a provider outside your HMO, or without your PCP's authorization, charges will not be covered. These costs do not apply to your annual out-of-pocket maximum.

Important – Evidence of Coverage Booklet

A summary of your benefits is included in Appendix H and Appendix I of this Handbook. However, it's important you have a copy of the **Evidence of Coverage** (EOC) booklet. The EOC has all plan details and should be your complete reference guide for information on:

- What services are covered
- The amount of your copayment for each service
- What is included in the annual out-of-pocket limit
- Pre-certification requirements and procedures
- How to file a claim, if needed
- How to appeal a claim

To get a copy of your plan's **Evidence of Coverage** booklet from the Employee Benefits Center, go online to **https://hrs.alamedacountyca.gov/employee-benefits-center/** or call 510-891-8991

Operating Engineers Health Plan

A select group of represented employees may enroll in the Operating Engineers Health Plan. This plan has bundled several benefits together and includes:

- Seven medical plan options
- Delta Dental PPO
- Vision care through VSP
- Life insurance
- A burial benefit

To determine if you are eligible for this benefits package, refer to your Memorandum of Understanding and/or Letter of Agreement. You can find details on these plans, costs, and information on how to enroll by contacting Operating Engineers directly at 800-251-5041 and press option 4 or online at **www.oe3publichealth.org**.

If you choose to enroll in this benefits package, you may not enroll in the County's medical or dental plans.

Where to Get Help from Your Plan

If you need help finding a provider or have questions about coverage that you cannot locate in the EOC, go to the plan's website or contact them by phone.

Kaiser Permanente	**my.kp.org/alamedacounty**	800-464-4000
UnitedHealthcare	**www.whyuhc.com/alameda**	800-624-8822
Operating Engineers Health Plan	**www.oe3publichealth.org**	800-251-5014, option 4

To access **Exploring Your Benefits**, scan the QR code.
CLICK HERE

Share-the-Savings

If you and/or your family are covered under another medical plan, you can save money by waiving or reducing the County-sponsored medical coverage you receive. If eligible, the Share-the-Savings program provides a taxable monthly stipend. The amount you can receive depends on the level of coverage you waive and your represented group.

These charts indicate the monthly stipend for full-time employees. If you work less than full-time, refer to Appendix F for the amount of the reduction based on your hours.

Employees Represented by: ACMEA Sheriff's Management Sworn, ACMEA Probation Managers, and Teamsters

If you...	You receive a monthly stipend of...
Decline all medical coverage	$200.00
Reduce medical coverage from Family to Self	$150.00
Reduce medical coverage from Family to Self+1	$100.00
Reduce medical coverage from Self+1 to Self	$100.00

Employees Represented by: ACPA, ACMEA DA Inspectors, ACWFIA and UAPD

If you...	You receive a monthly stipend of...
Decline all medical coverage	$250.00
Reduce medical coverage from Family to Self	$200.00
Reduce medical coverage from Family to Self+1	$150.00
Reduce medical coverage from Self+1 to Self	$150.00

Employees Represented by: ACCA, ACMEA General & Confidential, ACMEA Sheriff's Non-Sworn, BTC, DSA, CEMU, IFPTE Local 21 (016, 060, 077), PACE, PD, PPOA, SEIU, Unrepresented Managers and Unrepresented Non-Managers

If you...	You receive a monthly stipend of...
Decline all medical coverage	$300.00
Reduce medical coverage from Family to Self	$250.00
Reduce medical coverage from Family to Self+1	$200.00
Reduce medical coverage from Self+1 to Self	$200.00

How to Receive the Share-the-Savings Benefit

To receive the Share-the-Savings benefit, you must provide proof that you and/or your dependents are covered by an **eligible group medical plan**. Qualifying coverage may include a spouse's or domestic partner's employer-sponsored plan, **Medicare**, **Medi-Cal**, or another group medical plan.

New Hires or newly eligible employees must submit supporting documentation within 30 days of their hire or benefit eligibility date, and then each year thereafter during Open Enrollment. Each year, supporting documentation must be submitted to the EBC no later than the end of Open Enrollment. Documentation must be dated within 30 days of submission. Be sure your name and employee ID are clearly written on each page.

If, during Open Enrollment, you and/or your dependents are covered under another County employee's medical plan, you only need to complete the Documentation Certification Form available on the EBC website at: **http://alcoweb/hrs/ebc/default.htm**

Proof of Alternate Medical Coverage

All documentation must be dated within 30 days of submission **and** must clearly show:

- The effective date(s) of coverage
- The names of all covered individuals (including the employee, if applicable)
- The name of the alternate group medical plan (for example, Kaiser, Aetna, Blue Cross, Medicare, or Medi-Cal)

Acceptable documentation includes:

- A letter from the current medical plan administrator (such as a spouse's employer, Medicare, Medi-Cal, or another agency or organization)
- Benefits Confirmation Statement from employer
- A letter from the current medical insurance carrier confirming group coverage (for example, Kaiser, Aetna, or Blue Cross)
- An online printout from the medical carrier's website that includes all required information
- Other documentation that meets the criteria listed above

When Share-the-Savings Starts

If you enroll in Share-the-Savings during the annual Open Enrollment period, it becomes effective at the beginning of the new benefit plan year – February 1.

During the year, Share-the-Savings becomes effective at the same time your medical coverage starts (following two consecutive payroll earnings within the same month). Share-the-Savings payroll earnings will show on each semi-monthly paycheck.

Re-certify Alternate Medical Coverage each Year

If you participate in this benefit program, you must show proof of alternate coverage each year during the County's Open Enrollment period. If the County does not receive your documentation by the deadline, your Share-the-Savings stipend will stop the following benefit plan year.

Ineligible Coverage and Documentation

Coverage obtained in the individual insurance market, whether purchased through an Insurance Marketplace or directly from an insurer, does not qualify as acceptable alternative medical coverage for purposes of receiving the employer stipend.

The following documents will **not** be accepted as proof of coverage, including any documentation from an individual plan, or any Insurance Marketplace plan:

- Medical billing statements
- Medical or insurance ID cards
- Benefit summaries
- Enrollment or benefit election forms
- 1095 Forms

Where to Find Plan Details

See Appendix H and Appendix I for more information on what each plan covers, annual and lifetime maximums, and any out-of-pocket costs for:

- Kaiser Permanente Traditional HMO – with $15 or $40 copayment
- UnitedHealthcare's SignatureValue HMO – with $15 or $40 copayment
- UnitedHealthcare's Select Plus PPO

Details are also provided in the Evidence of Coverage for each plan at: **https://hrs.alamedacountyca.gov/employee-benefits-center/**

The County provides eligible employees a choice of two dental plans plus a supplemental plan for families with two members who both work for the County.

- DeltaCare USA – a Dental HMO
- Delta Dental PPO
- Delta Dental PPO Supplemental Plan

Both DeltaCare USA and the Delta Dental PPO provide important preventive care – exams, cleanings, X-rays and fluoride treatment – at 100%. Other care includes fillings, crowns and orthodontia for both children and adults.

Dental Cards

Unlike the medical plans, you do not receive a dental identification card. If you like, visit Delta's website to download a digital copy or print your own by logging in with your social security number.

When Coverage Starts

Deductions for your dental plan are on a semi-monthly basis. Your coverage starts the first of the month, after two payroll deductions in a single month have been taken. For example:

- You are hired on **January 2**
- You work two pay periods in the month of **February**
- Dental coverage starts **March 1**

Your Cost

Regardless of the plan you select, the County pays 100% of the premium cost for you and your enrolled family members.

NOTE: If you work fewer than the standard hours in a given pay period, the County contribution may be reduced. In the event you are on a leave without pay for more than 5 days, 100% of the cost will be your responsibility either through paycheck deduction or through the benefit billing process.

DeltaCare USA

DeltaCare USA is a dental HMO plan. Like a medical HMO, you are required to select a primary care dentist from DeltaCare's network. Your primary dentist provides basic dental care and is responsible for referring you to specialist when needed. The plan does not cover any dental care provided outside the DeltaCare USA network. This plan has no annual maximum, you pay no deductible and most care is provided at 100%.

Delta Dental PPO

With this plan, you can access dentists in both the Delta Dental PPO network and their Premier network. When you get dental care from a dentist in either network, your cost is lower than if you get care from a non-network dentist. PPO network dentists have agreed to discounted fees so when you visit a PPO dentist, your out-of-pocket costs are lower, and your plan year maximum goes further.

Except for preventive care (which has no deducible), you pay a $45 annual deductible and have an annual maximum. When visiting a Delta Dental PPO dentist, basic services such as fillings are covered at 85%. If you visit a non-network dentist, the dental plan will pay 80% up to the Maximum Plan Allowance.

Unlike the DeltaCare USA plan, the Delta Dental PPO plan also covers implants and mouth guards that stop the progression of damage from TMJ and teeth grinding.

A Word about Maximum Plan Allowance (MPA)

This is the amount Delta Dental recognizes as the maximum they will cover when you see a dentist outside of their network. You are responsible for paying any amount that your dentist charges for a procedure above the MPA.

Orthodontia Maximums

The Orthodontia maximum for the PPO Plan is 50% up to $2,500 lifetime maximum.

Annual Maximum Benefit

Your dental plan annual maximum depends on your eligibility/bargaining group. Benefit plan year begins February 1 and ends January 31 of the following year.

$1,550 Maximum	$1,650 Maximum	$1,750 Maximum	$1,900 Maximum
• ACMEA Sheriff's Sworn • Teamsters 856	• ACMEA Probation Managers • ACWFIA • PPOA Safety & Non-Safety	• ACPA (District Attorney) • ACMEA DA Inspectors • UAPD	• ACCA • ACMEA General & Confidential • ACMEA Sheriff's Non-Sworn • BTC • CEMU • DSA • IFPTE Local 21 (016, 060, 077) • PACE • Public Defender • SEIU • Unrepresented Managers • Unrepresented Non-Management related to SEIU, BTC & others

Delta Dental PPO Supplemental Plan

This plan is available for spouses, domestic partners, and/or Young Adult Dependents (YADs), up to age 26 who are also employed by the County **and** enrolled in the County's Delta Dental PPO Plan. This Plan supplements the benefits provided under the County-sponsored Delta PPO dental plan by up to 25%.

To participate, one employee would select self+1 or family coverage in the Delta Dental PPO Plan, and the spouse/domestic partner selects the Supplemental Plan with self+1 or family coverage. The benefits provided to the spouse/domestic partner as eligible dental expenses are incurred throughout the year. The Supplemental Plan also increases the current maximum benefit by $600 and waives the $45 deductible.

Where to Find Plan Details

See Appendix J for more information on what each plan covers, annual and lifetime maximums, and any out-of-pocket costs for:

- DeltaCare USA – a Dental HMO
- Delta Dental PPO
- Delta Dental PPO Supplemental Plan
- Comparison Chart of Dental Options

Details are also provided in the **Evidence of Coverage** for each plan at **Evidence of Coverage Booklets | HRS**

The County provides eligible employees a choice of two voluntary vision plans through Vision Service Plan (VSP) and their extensive network of providers:

- Vision Choice Plus
- Vision Choice Premium

Both plans provide an annual Wellvision exam and lenses, if needed, for a $15 copayment. The plans include a selection of glasses and frames or contact lenses, lens enhancements and non-prescription sunglasses up to a dollar maximum. How often you can get frames and the amount of the dollar limit depends on the plan you select – with the Premium plan offering a more generous allowance. Discounts are also available on additional glasses, sunglasses, and laser vision correction. If you see a vision care provider outside the VSP network, your out-of-pocket costs may be higher.

Plan Eligibility

Your eligibility to enroll in a vision plan is discussed in your Memorandum of Understanding. Regular employees are eligible for the vision plans except SAN and Teamsters.

Vision Reimbursement Plan

Members of some labor organizations not included in the list above are instead eligible for the Vision Reimbursement Plan. Eligible groups:

- Teamsters 856

How the Vision Reimbursement Plan Works

If you are enrolled in a County medical plan, that plan includes a basic annual eye exam. If you have an eye exam through your medical plan and find that you need vision correction, you can submit a claim to the County for reimbursement of the cost of glasses and frames or contact lenses every 24 months up to a $200 limit. The Vision Reimbursement Plan is for employees only, not your dependents.

You become eligible for reimbursement after 6 months of continuous employment working at least 50% time or more per pay period.

When Coverage Starts

Deductions for your vision plan are on a semi-monthly basis. Your coverage starts after two payroll deductions in a single month. For example:

- You are hired on **January 2**
- First payroll deductions are taken from your two paychecks in **February**
- Vision coverage starts **March 1**

If the County cannot take two consecutive deductions in a given month, coverage becomes effective the first of the month following the month after two consecutive deductions can be taken.

Your Cost

Since these are voluntary plans, if you choose to enroll, you pay the full cost of coverage. The cost for individual, two-party, or family coverage can be found in Appendix D.

Vision Choice Plus

This plan covers an eye exam, lenses or contacts every 12 months, frames every 24 months, and discounts on lens options, additional glasses, sunglasses, and laser vision correction. The frame allowance is $150 **every other plan year**.

Vision Choice Premium

This plan option covers an eye exam, lenses or contacts every 12 months, frames every 12 months, and discounts on lens options, additional glasses, sunglasses, contacts, and laser vision correction. Progressive lenses and/or Anti-reflective coating are covered after a $25 copay, per service selected.

Single vision, lined bifocal, and lined trifocal lenses are covered 100%. Polycarbonate, Photochromic, including Transitions lenses are covered 100%. Progressive lenses are fully covered after a $25 copay. The frame allowance is $250 **every plan year**.

NOTE: Your eligibility for benefits will follow the frequency of your elected plan. For example, if you had the Premium plan and received frames the previous year, e.g., 2024, and then elected the Plus plan for the current year, e.g., 2025, you are not eligible for frames until 2026.

Getting the Most out of Your VSP Plan

Use VSP Network Providers

You receive the best value and savings when services are received from an in-network provider. Walmart is now a contracted provider with VSP.

Open Access

Open Access means you can use your VSP benefit with any Choice network provider, including national chains and even non-VSP doctors. While coverage is best when using a network provider, VSP offers a reimbursement schedule for services from all other providers. VSP keeps it simple by allowing providers to contact VSP directly to check eligibility and submit claims directly to VSP. VSP then pays the provider up to the scheduled amounts, so you would only be responsible for paying any amounts above the allowances. When calling or visiting a VSP provider be prepared to provide your County Employee-ID number, beginning with three leading zeros (for example, 000123456).

LightCare

If you are enrolled in one of the vision plans but do not need prescription glasses, you have the option to purchase sunglasses at the same copay and frame allowance as prescription glasses.

Computer VisionCare

If you are enrolled in one of the vision plans, you may have an exam and purchase blue light blocking glasses to help combat digital eye strain.

You Can Now Use VSP at Walmart

Walmart is contracted with VSP. You can now use Walmart services at in-network pricing.

NOTE: Please check with VSP to ensure the eye doctor providing the exam is contracted. These are independent providers and some may not be contracted with VSP.

You Can Coordinate VSP with Kaiser

While Kaiser is not considered an in-network provider, VSP can provide reimbursement for services obtained at a Kaiser location, based on the out-of-network schedule of benefits.

Out-of-Network Services

You get the best value and savings when receiving services within the VSP network. If you choose to receive services from a non-preferred provider or retailer, VSP will reimburse services based on your plan's out-of-network schedule.

NOTE: Services must be obtained either out-of-network or in-network. VSP will not pay for both.

Submitting Out-of-Network Claims

VSP makes it easy to receive reimbursement. Simply submit your itemized receipt to VSP (claim form available on **vsp.com**) and you will be reimbursed up to your plan's out-of-network schedule. Checks will be sent within 5 days from receipt.

See Appendix K for a comparison chart with a more complete list of what each plan covers, how often you can get vision correction lenses, your out-of-pocket costs and dollar limits. Details are provided in the Evidence of Coverage for each plan at **https://alcoweb.acgov.org/hrs/benefits/evidence.htm**.

Where to Find Plan Details

See Appendix K for more information on what each plan covers, annual and lifetime maximums, and any out-of-pocket costs for:

- Vision Choice Plus
- Vision Choice Premium

Details are also provided in the **Evidence of Coverage** for each plan at **https://hrs.alamedacountyca.gov/employee-benefits-center/**.

Visit **vsp.com** to check your benefits, find a VSP provider near you, or print an out-of-network claim form.

Depending on your union contract and/or Memorandum of Understanding, the County provides a certain level of **Basic Life Insurance** (fully paid by the County). You may also have the option to purchase **Supplemental Life Insurance** and **Accidental Death & Dismemberment (AD&D) Insurance** (for Management only), for yourself and your dependents. For detailed information on each of the life insurance coverages available to you, review the **Evidence of Coverage** booklet located on the EBC Online website. Go to **Healthcare and Insurance Benefits** then look for **Evidence of Coverage** Booklets. You can also contact the Employee Benefits Center for more information.

Eligibility

Eligibility for each insurance plan discussed in this section is negotiated separately by your organization, as well as the level of coverage you may purchase in each plan. The bargaining groups and other eligible organizations (organized by **Class**) are listed under each benefit in the section.

Active Service

If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met:

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Designate a Beneficiary

When you first become eligible for Life Insurance, you should complete a Beneficiary Designation Form available from the EBC or at **EBC Forms | HRS**. You may change your beneficiary(ies) at any time by completing a new form or during Open Enrollment, through the eBenefits enrollment system.

If you die without naming a beneficiary, your Death Benefit can be tied up in probate or paid to the first surviving relative in this order: spouse, child(ren), mother or father, siblings, or the executor or administrator of your estate.

If you enroll your spouse and/or dependents in the Voluntary Supplemental Life Insurance plan, you are automatically the beneficiary.

Basic Life Insurance

You are automatically enrolled and the coverage becomes effective on your date of hire or date of eligibility, if later. The County pays 100% of the cost of coverage. If you die while employed by the County, your Basic Life Insurance benefit is paid in a single lump sum to your beneficiary(ies).

Bargaining Unit Class		Negotiated Coverage Amount
1	• All active full- and part-time unrepresented non-management • Employees subject to the collective bargaining agreement by **SEIU 1021** and **Probation Peace Officers** and regularly scheduled to work at least 50% time, excluding temporary and service as needed employees • All active full- and part-time non-management employees subject to the collective bargaining agreement with **IFPTE Local 21 (016, 060, 077)** and regularly scheduled to work at least 50% time, excluding temporary and service as needed employees	$20,000
2	All active full- and part-time non-management employees of the **Deputy Sheriff's Association** and regularly scheduled to work at least 50% time, excluding temporary and service as needed employees	$12,000
4	All active full- and part-time non-management employees subject to the collective bargaining agreement with **U.A.P.D. Unit 18** and regularly scheduled to work at least 50% time	$25,000
5	All active full- and part-time **represented and unrepresented management employees** including **Superior Court Judges** regularly scheduled to work at least 50% time, excluding temporary and service as needed employees Excluding Board of Supervisors, elected Officials and Agency/Department Heads	$25,000
6	All active full- and part-time management employees who are members of the **Board of Supervisors, Elected Officials and Agency/Department Heads** regularly scheduled to work at least 50% time, excluding temporary and service as needed employees	$75,000
9	**BTC and Teamsters**	$15,000

Voluntary Supplemental Life Insurance Programs

If eligible, you may purchase Supplemental Life Insurance coverage for yourself, your eligible spouse/domestic partner and/or eligible dependent child(ren). Coverage amounts are negotiated by your labor organization.

IMPORTANT: If you and another family member both work for the County, you can only be covered under one Voluntary plan. For example, you cannot be covered as an employee and also as a dependent under your spouse's plan. If the County or the insurance company find you have double coverage, your coverage will be terminated with no premium refund.

When Coverage Starts

As long as you are considered in **Active Service**, Life & AD&D insurance coverage starts the first of the month after your date of hire or date of eligibility, if later.

If you change your level of coverage during Open Enrollment, the change becomes effective January 1 after the close of Open Enrollment, or the first of the month following the review and approval of your **Evidence of Good Health**.

Active Service

If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met:

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Evidence of Good Health

This is an insurance company form you must complete when you increase your coverage above the amount you select when you first enroll (or, you enroll for the first time after declining to enroll when first eligible). The Evidence of Good Health form must be reviewed and approved by the insurance company before the new amount can go into effect.

Voluntary Employee Supplemental Life Insurance

If you enroll when this benefit is first offered, you may purchase coverage in increments of $10,000 up to a dollar maximum based on:

- Your annual rate of basic earnings, and
- An amount negotiated by your labor organization.

Guarantee Issue Amount – This is the amount of coverage you may purchase when this benefit is first offered and without having to provide the insurance company with Evidence of Good Health.

If you purchase less than the Guarantee Issue Amount and want to increase your coverage amount at a later time, you must complete an Evidence of Good Health form and receive approval from the insurance company before the new amount can go into effect.

Your Organization	Guarantee Issue Amount	Overall Maximum
Non-management employees represented by: • BTC • DSA • IFPTE (016, 060, 077) • SEIU 1021 • PPOA • Unrepresented non-managers • Teamsters	The lesser of: • $300,000 • 3 times annual salary	$300,000
Union of American Physicians and Dentists	The lesser of: • $500,000 • 3 times annual salary	$500,000
Management	The lesser of: • $500,000 • 3 times annual salary	The lesser of: • $1 million • 5 times annual salary

General Information on Voluntary Spouse and Child Supplemental Life Insurance

These plans are only available to Management employees in Class 5 and 6 (see page 20).

Eligibility

To be eligible for coverage on the date insurance becomes effective, the dependent you are enrolling must meet the definition of Active Service for Dependent. If an eligible Spouse or Dependent Child is:

1. An inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or

2. Confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, the provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

Monitoring Coverage Eligibility

The County does not maintain or monitor the dependents covered under the Voluntary Supplemental Spouse or Child Life plans. It is your responsibility to make sure your enrolled dependents meet all eligibility requirements. The insurance carrier reserves the right to confirm or determine eligibility for dependents at time of claim.

Double Coverage

Remember, double coverage is prohibited. Coverage is not available under Supplemental Spouse or Child Life if that individual is covered as an employee.

Supplemental Spouse Life Insurance

You can purchase Supplemental Spouse Life insurance for your spouse/partner increments of $10,000 to a maximum of:

- $100,000 without evidence of good health, or
- $150,000 with evidence of good health.

The amount of spouse coverage can never exceed 100% of the amount of Supplemental Life Insurance in force for you, the employee.

Supplemental Child Life Insurance

You can purchase Supplemental Child Life in increments of $5,000 to a maximum of $15,000. When you purchase Supplemental Child Life, you cover all dependent children up to age 26 (if not married) and disabled children primarily dependent on you for financial support.

For a child less than six months old, the benefit payout is only $250, no matter what coverage level you choose when you enroll.

The amount of child life can never exceed 50% of the amount of Supplemental Life Insurance in force for you, the employee.

Your Cost

Since these are voluntary plans, if you choose to enroll, you pay the full cost of coverage. Your premium cost is based on your age as of January 1 of each plan year. This means, the first of the year following Open Enrollment. For example, Open Enrollment takes place in October for the following Plan Year. Use your age as of January 1 in the new Plan Year.

To calculate the Supplemental Employee Life semi-monthly cost, take the amount of coverage you want to purchase

divided by $1,000 = $_____ x your age-banded rate = $_____ (your cost).

Find the age-banded rates in your new hire package and each year in the Open Enrollment materials.

The semi-monthly cost for Supplemental Spouse Life is based on your spouse's/partner's age as of January 1 of the new plan year. Then use the same formula as above.

Accidental Death & Dismemberment (AD&D) Insurance

This plan is only available to Management employees in Class 5 and 6 (see page 24) and, if you enroll, starts the same time as Voluntary Life Insurance.

What is Covered

In the event of an accidental death, AD&D insurance pays a benefit in addition to any life insurance but only up to a set amount regardless of any other insurance held by the insured per the Evidence of Coverage.

The dismemberment part of this insurance pays a fractional benefit of the coverage amount – if you lose a bodily appendage or sight because of an accident. Additionally, AD&D generally pays benefits for the loss of limbs, fingers, sight and/or permanent paralysis. The benefit amount varies depending on the type of injury.

Find more detailed information in the Certificate of Coverage located on the EBC Online website under **Healthcare and Insurance Benefits**, then **Certificate of Coverage**.

Coverage Amount

You may choose to purchase AD&D Insurance coverage for yourself only or you and your family. You can purchase in increments of $25,000 to a maximum of $500,000, not to exceed 10 times your annual base salary.

Calculating Costs

Since these are voluntary plans, if you choose to enroll, you pay the full cost of coverage.

To calculate the AD&D Employee or Family semi-monthly cost, take the amount of coverage you want to purchase

divided by $1,000 = $_____ x the rate = $_____ (your cost).

You will find the rates in your new hire package and in your Open Enrollment materials each year.

Additional Information on Death Benefits

Reminder, for detailed information on each of the life coverages available to you, review the Certificate of Coverage. The following are some additional details about death benefits. The Insurance Company may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless

the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

All other benefits, unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to $1,000 to a relative by blood or marriage to whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Important

When you reach age 65, the amount of Life & AD&D Insurance will decrease by 35% the first of the month following the date you/your spouse reach age 65.

Basic & Supplemental Life Insurance Additional Benefits

Since you are enrolled in one or more of the life insurance plans available through the County, you also have access to these special programs and services provided by New York Life, the County's insurance carrier. These programs help protect your health, well-being and sense of security.

Program	Description
Survivor Assurance	Provides support services for beneficiaries when they need it most—when they have lost a loved one. Includes a free, interest-bearing account for claim payments of $5,000 or more and the ability to manage balances and activity 24/7. The "Where to Go from Here" flyer describes the other New York Life Group Benefit Solutions programs available to beneficiaries, including bereavement counseling, and access to a variety of financial and legal services. For more information, call (800) 570-3778 weekdays between 8:00 am and 7:00 pm, (EST) or go to http://www.nylgbssurvivorassurance.com/.
New York Life Secure Travel	As part of your New York Life insurance, Secure Travel is available when you travel more than 100 miles from home. It provides services that help with pre-trip planning, assistance while traveling, and emergency medical transportation benefits and may include help with inoculations and Visa requirements, medication replacement, cash advances, locating lost items or contacting family. To learn more, call 347-708-1824, and mention policy number OK 980330, County of Alameda.
Life Assistance Program (offered through ComPsych)	Provides support services for whatever life throws at you and can help your family find solutions and restore your peace of mind. Includes phone calls anytime, three face-to-face sessions with a behavioral counselor for you and household members, monthly webinars on relevant topics, and legal and financial counseling and free 30-minute consultations and discounted fees. For more information, call 1-800-344-9752 or visit http://guidanceresources.com – Registration Web ID: NYLGBS.

Eligible employees have the option to purchase one or both disability plans described in this section. Both plans pay a portion of your earnings if you cannot work due to a disabling illness or injury that keeps you away from work. Each plan has a specific waiting period before benefits start and a dollar limit. Generally,

- **Short-term Disability (STD)** benefits start on your eighth day of disability and can continue up to 25 weeks.
- **Long-term Disability (LTD)** benefits start after you have been disabled for 180 days and continue, until the earliest of the end of your disability or you reach Social Security retirement age.

Eligibility

You are eligible to enroll if you are an active full-time or part-time employee who works at least 50% time, unless you are in one of these groups:

- Temporary, service as needed employees
- Employees represented by the Deputy Sheriff's Association
- ACMEA Sheriff's Management Unit

When to Enroll

You may enroll when you are hired, when you become eligible, or during open enrollment. Evidence of Good Health is no longer required, even if you decline to enroll in coverage when you first become eligible.

When Coverage Starts

Deductions for your disability plans are on a semimonthly basis and start the month after your hire date or date of eligibility. Your coverage starts the first day of the month in which two payroll deductions are taken in a single month. For example:

- You are hired on **January 2**
- First payroll deductions are taken from your two paychecks in **February**
- Disability coverage starts **February 1**

If the County cannot take two consecutive deductions in a given month, coverage becomes effective the first of the month following the month after two consecutive deductions can be taken.

Active Service

You are considered in Active Service if you are employed on a day which meets either of these conditions:

1. You are actively at work and performing your regular occupation, either at one of the County's usual places of business or at some location to which the County's business requires you to travel, or

2. The day is a scheduled holiday, vacation day or period of County-approved paid leave of absence, except after the seventh day of disability or sick leave.

You are considered in Active Service on a day which is not a regularly scheduled workday only if you were in Active Service on the preceding scheduled workday.

Pre-existing Conditions

Pre-existing conditions do apply if you had disability coverage through your previous employer and coverage was terminated before your new effective date of this new LTD policy. Otherwise, pre-existing conditions will apply until you have been continuously covered under the County's LTD policy for 12 consecutive months. A pre-existing condition is any illness or injury for which you received medical care or treatment during the three months before your effective date of coverage.

Your Cost

Since these are voluntary plans, if you choose to enroll, you pay the full cost of coverage. STD and LTD premiums are based on your age as of January 1 each year **and** your annual base salary as reported in the Human Resource Management System. You may see a change in the amount deducted if:

- Your birthday moves you into a different age band, or
- You receive a salary increase or decrease.

The cost for each plan is listed in Appendix D. See the **Summary** for STD and LTD on the next page for how to calculate your cost.

Summary of your STD Benefit

Starting on the eighth day of an accident or sickness, the Voluntary Short-term Disability Plan pays you up to 40% of your eligible base earnings up to a maximum of $1,500/week. This plan pays a benefit for up to 25 weeks, then stops.

To calculate your semi-monthly cost, first divide your annual salary (up to $195,000) by 52 to determine your weekly salary.

Weekly salary $_____ times the STD age-banded rate = $_____divided by 100 = $_____ times 4.333 = $_____ (your semi-monthly cost).

Summary of your LTD Benefit

Long-term Disability does not start until your disability continues beyond 180 days. The plan pays a monthly income replacement of up to 60% of your eligible base salary, to a maximum of $5,000/month. You can continue to receive benefits until the earliest of your recovery or you reach Social Security retirement age. If your disability starts after age 65, the insurance company may reduce your monthly benefit.

NOTE: You can only purchase coverage for up to $100,000 of your annual base salary.

To calculate your semi-monthly cost, first divide your annual salary (up to $100,000) by 12.

Monthly salary $_____ times the LTD age-banded rate $_____ = $_____divided by 100 = $_____ (your semi-monthly cost).

These summaries cover only the most commonly used/asked-about benefits. For a complete explanation of all benefits, please refer to the **Evidence of Coverage** (EOC) document for each plan.

Voluntary Short-term Disability Insurance

These highlights are an overview of your Voluntary Short-term Disability Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

What is Voluntary Short-term Disability Insurance?	Voluntary Short-term Disability Insurance pays you a portion of your Earnings if you cannot work because of a disabling illness or injury.
What is disability?	You are considered disabled if, solely because of injury or sickness, you are unable to: • Perform the material duties of your regular occupation, and • Earn 80% or more of your covered earnings from working in your regular occupation. The insurance company will require proof of earnings and continued disability.
Am I eligible?	You are eligible if you are an active full-time or part-time County of Alameda employee who works at least 50% of the time as designated by the County, excluding temporary, service as needed employees, and employees represented by the Deputy Sheriff's Association and ACMEA Sheriff's Management Unit.
How much coverage would I have?	You may purchase coverage that would pay you a benefit of 40% of your weekly earnings. The maximum STD benefit you could receive is $1,500 per week. This coverage supplements any CA SDI benefit to bring your income closer to your pre-disability level of income. Earnings are defined by the County.
When can I enroll?	You must elect coverage within 31 days of your eligibility waiting period which is the first of the month following 30 days from your initial eligibility date.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than the first of the month following 30 days from your initial eligibility date. You must be Actively at Work with the County on the day your coverage takes effect.
How long do I have to wait before I can receive my benefit?	Once you are approved for coverage, you will be eligible to collect your STD Insurance benefit starting on the eighth day after your accident or eighth day of sickness. Your benefit could continue for up to 25 weeks.
If I'm disabled, can the amount of my benefit be reduced?	Yes. As described on the following page, your monthly STD benefit may be reduced by other income you receive.
Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a "late entrant." Typically, late entrants must show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required.

Active Service

An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met:

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Exclusions

The insurance company will not pay any disability benefits for a disability that results, directly or indirectly, from:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane.
- War or any act of war; whether or not declared.
- Active participation in a riot.
- Commission of a felony.
- The revocation, restriction or non-renewal of an employee's license, permit or certification necessary to perform his/her occupational duties unless due solely to injury or sickness otherwise covered by the policy.
- Any cosmetic surgery or surgical procedure that is not medically necessary. Medically necessary means the surgical procedure is:
  a. prescribed by a physician as required treatment of the injury or sickness, and
  b. appropriate according to conventional medical practice for the injury or sickness in the locality in which the surgery is performed. (The insurance company will pay benefits if the disability is caused by the employee donating an organ in a non-experimental organ transplant procedure.)
- An injury or sickness for which the employee is entitled to benefits from workers' compensation or occupational disease law.
- An injury or sickness that is work related.

In addition, the Insurance Company will not pay disability benefits for any period of disability during which you are incarcerated in a penal or correctional institution.

Pre-existing Conditions

This policy will not provide coverage for any period of disability beginning within the first 12 months of the effective date of your coverage under this policy if the period of disability is caused by or substantially contributed to by a pre-existing condition or the medical or surgical treatment of a pre-existing condition.

You have a pre-existing condition if:

- You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the three months immediately before the effective date of coverage under this insurance, or
- You suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your application and:
  a. for which you received a physician's advice or treatment within three months before the date of your coverage under this policy, or
  b. which caused symptoms within three months before the date of issue for which a prudent person would usually seek medical advice or treatment.

Benefit Reduction

Your benefit payment will be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

Exceptions

Your benefit payments will not be reduced by certain kinds of other income, such as:

- Coordination with SDI, sick leave, or salary continuation
- Retirement benefits if you were already receiving them before you became disabled
- Retirement benefits you start to receive that are funded by your after-tax contributions
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Personal disability policies
- Social Security increases

Voluntary Long-term Disability Insurance

These highlights are an overview of your Voluntary Long-term Disability Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

What is Voluntary Long-term Disability Insurance?	Voluntary Long-term Disability Insurance pays you a portion of your Earnings if you cannot work because of a disabling illness or injury.
What is disability?	You are considered disabled if, solely because of injury or sickness, you are unable to: • Perform the material duties of his or her Regular Occupation, and • Earn 80% or more of your indexed earnings from working your regular occupation. After disability benefits have been payable for 24 months, you are considered disabled if, solely due to injury or sickness, you are unable to: • Perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience, and • Earn 80% or more of your indexed earnings. The insurance company will require proof of earnings and continued disability.
Am I eligible?	You are eligible if you are a full-time or part-time County employee who works at least 50% of the time as designated by the County, excluding temporary, service as needed employees, and employees represented by the Deputy Sheriff's Association and ACMEA Sheriff's Management Unit.
How much coverage would I have?	You may purchase coverage that pays you a benefit of 60% of your earnings to a maximum benefit of $5,000 per month. This plan includes a minimum benefit of the greater of: • 10% of the benefit based on monthly income loss before the deduction of other income benefits, or • $100 per month. Earnings are defined by the County.
When can I enroll?	You must elect coverage within 31 days of your eligibility waiting period which is the first of the month following 30 days from your initial eligibility date.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than the first of the month following 30 days from your initial eligibility date. You must be Actively at Work with your employer on the day your coverage takes effect.
How long do I have to wait before I can receive my benefit?	You must be disabled for at least 180 days before you can receive LTD insurance payments.
Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant. Typically, late entrants must show Evidence of Good Health and may be responsible for the cost of physical exams or other associated costs if they are required.
Can the duration or amount of my benefit be reduced?	An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.
How long will my disability payments continue?	For as long as you are certified as disabled, or until you reach your Social Security Normal Retirement Age, whichever is sooner. If your disability occurs at age 65 or over, your payments may be limited.

Active Service

An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met:

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not on of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Exclusions

The insurance company will not pay any disability benefits for a disability that results, directly or indirectly, from:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane.
- War or any act of war; whether or not declared.
- Active participation in a riot.
- Commission of a felony.
- The revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the Insurance Company will not pay disability benefits for any period of disability during which you are incarcerated in a penal or correctional institution.

Any period of time you are confined in a hospital or other facility license to provide medical care for mental illness, alcoholism or substance abuse does not count toward the 24 months lifetime limit.

Limited Benefit Periods for Mental or Nervous Disorders

The insurance company will pay disability benefits on a limited basis during an employee's lifetime for a disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly disability benefits have been paid, no further benefits will be payable for any of these conditions:

- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Eating disorders
- Mental illness
- Somatoform disorders (psychosomatic illness)

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions previously listed.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse

The insurance company will pay disability benefits on a limited basis during your lifetime for a disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly disability benefits have been paid, no further benefits will be payable for any of these conditions:

- Alcoholism
- Drug addiction or abuse

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

Other Income Benefits

An employee for whom disability benefits are payable under this policy may be eligible for benefits from other income benefits. If so, the insurance company may reduce the disability benefits by the amount of such other income benefits.

Other income Benefits include:

1. Any amounts received (or assumed to be received*) by you or your dependents under:
   - The Canada and Quebec Pension Plans.
   - The Railroad Retirement Act.
   - Any local, state (SDI), provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the County.
   - Any sick leave or salary continuation plan of the County.
   - Any work loss provision in mandatory No Fault auto insurance.
2. Any Social Security disability or retirement benefits you or any third party receives (or is assumed to receive*) on your behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
3. Any Retirement Plan benefits funded by the County. Retirement Plan means any defined benefit or defined contribution plan sponsored or funded by the County. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. Any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability; and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. Pro rata share means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. Any amounts received (or assumed to be received*) by you or your dependents under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law payable for injury or sickness arising out of work with the County, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of an employee's entitlement to benefits.

*See the **Assumed Receipt of Benefits** provision below.

Increases in Other Income Benefits

Any increase in other income benefits during a period of disability due to a cost of living adjustment will not be considered in calculating your disability benefits after the first reduction is made for any other income benefits. This section does not apply to any cost of living adjustment for disability earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an other income benefit.

Assumed Receipt of Benefits

The insurance company will assume you (and your dependents, if applicable) are receiving benefits for which they are eligible from other income benefits. The insurance company will reduce your disability benefits by the amount from other income benefits it estimates are payable to you or your dependents.

The insurance company will waive assumed receipt of benefits, except for disability earnings for work you perform while disability benefits are payable, if you:

- Provide satisfactory proof of application for other income benefits,
- Sign a reimbursement agreement,

- Provide satisfactory proof that all appeals for other income benefits have been made unless the insurance company determines that further appeals are not likely to succeed, and
- Submit satisfactory proof that other income benefits were denied.

The insurance company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Social Security Assistance

The insurance company may help you in applying for Social Security Disability Income (SSDI) benefits, and may require you to file an appeal if it believes a reversal of a prior decision is possible.

The insurance company will reduce disability benefits by the amount it estimates you would receive if you applied for SSDI benefits, if you refuse to cooperate with or participate in the Social Security Assistance Program.

This benefit is only available during Open Enrollment. It allows eligible employees to use their annual vacation accrual to purchase Short-term Disability (STD) and/or Long-term Disability (LTD) coverage for the following plan year.

Who's Eligible

Check eligibility for this benefit with your labor organization's current Memorandum of Understanding, the County's Salary Ordinance or Administrative Code.

How it Works

If eligible, this benefit will be included on your Open Enrollment form and through eBenefits. You can either elect to pay your STD and/or LTD premium by:

- Having your disability premiums paid through a semi-monthly payroll deduction, or
- Using the annual Vacation Sellback option.

Regardless of how you decide to pay for STD and/or LTD, your birth date as of January 1 following Open Enrollment will be used to calculate your premiums.

When using the Vacation Sellback Benefit, keep in mind that the vacation days will be taxed and then the remaining balance is applied towards the plan premiums. If you do not have enough vacation to cover the annual premiums, the remaining amount will be taken as an after-tax payroll deduction.

Even if you elected Vacation Sellback as an option to pay your disability premium last year, the default at Open Enrollment will be payroll deduction. You must actively elect the Vacation Sellback Benefit each year.

Flexible Spending Accounts help you plan for certain expenses while reducing your taxes. They allow you to set aside before-tax money to pay for:

- Certain healthcare expenses, copays, and some over-the-counter drugs, medications and other items not covered by your medical, dental or vision plans.
- Dependent day care expenses.
- Adoption expenses.

Your Flexible Spending Account contributions are taken out of each paycheck before taxes are calculated. You pay your expenses, file a claim, and then you are reimbursed from the before-tax dollars in your Spending Account. If eligible, you may participate in one or all of the Spending Accounts.

Eligibility

Employee eligibility is based on your labor group's Memorandum of Understanding and your classification. See Appendix C (listed by labor group) to determine your eligibility for each of the three Spending Accounts.

When Coverage Starts

Deductions for each of the Spending Accounts you enroll in are on a semi-monthly basis and start the month after your hire date or date of eligibility. If you enroll, coverage starts the first day of the month in which two payroll deductions are taken in a single month. For example:

- You are hired on **January 2**
- First payroll deductions are taken from your two paychecks in **February**
- Spending Accounts coverage starts **February 1**

To access a Benefits Educational Video on **How to Use Your FSA**, or scan the QR code. **CLICK HERE**

How Flexible Spending Accounts Work

Based on your expected healthcare, adoption and/ or dependent care expenses, you decide how much to contribute annually to each of these accounts. The County deducts your contributions in equal increments over 24 pay periods* on a before-tax basis. As you incur eligible expenses, you submit those claims to Optum Financial (formerly ConnectYourCare), the County's Flexible Spending Account administrator, for reimbursement.

NOTE: If you enroll in the Health FSA, Optum Financial provides you with a debit card to use for your healthcare expenses. See **Health FSA Claims** for more information on how it works.

The Internal Revenue Service determines the annual maximum you can contribute. For 2026:

- Health FSA — Up to $3,300
- Dependent FSA – Up to $$7,500 per household ($3,750 if married and filing separately)
- Adoption Assistance FSA – Up to $6,000 if you are in an eligible group. Check Appendix C to confirm your eligibility.

NOTE: These contribution maximums include any remaining County Allowance allocations you choose to use toward the Federally mandated maximum.

***If you enroll during the year when first hired or first become eligible, your contribution will be deducted in equal amounts over the remaining pay periods for that year.**

Plan Carefully

This is a use it or lose it benefit, so be sure to plan your Flexible Spending Account contributions carefully. Any unused balances in your account(s) at the end of the calendar year are forfeited if you do not submit a claim for services you incurred this year. This is an IRS rule and not regulated by the County.

You have until April 15 of the following year to submit all claims for services you incurred the previous year.

Re-enrollment Required. These accounts do not automatically renew. You **must** re-enroll each year during Open Enrollment, even if you currently participate. Be sure to indicate your Flexible Spending Account election using the online eBenefits worksheet if you wish to contribute for the coming year.

Health Flexible Spending Account (Health FSA)

You can set aside pre-tax dollars through salary contributions into the Health FSA. This account allows you to reimburse yourself with those tax-free dollars to pay for eligible healthcare expenses. For a detailed description of IRS eligible expenses for reimbursement, type this link into your internet's URL **http://www.irs.gov/pub/irs-pdf/p502.pdf**.

NOTE: Money from your County Allowance that you have not used towards your Medical, Vision, Supplemental Employee Life and/or AD&D can also be credited to this account. Check your labor organization's current MOU for your County Allowance eligibility. The amount of the allowance for each group is listed in Appendix C.

Adoption Assistance Flexible Spending Account

If you are in an eligible group, this account lets you set aside pre-tax dollars to reimburse yourself for eligible adoption expenses. You can also use any funds remaining in your County Allowance toward this Spending Account.

Eligible expenses are those associated with adopting a child or children who are:

- Under 18 years of age, or
- Physically or mentally incapable of self-care.

Expenses eligible for reimbursement include:

- Reasonable and necessary expenses for private, public and international adoption agencies' services
- Reasonable legal fees
- Application fees and dossier preparation
- Immigration, immunization and translation fees
- Orphanage fees
- Court costs
- Cost of child care when the child must live temporarily at another location before placement in your home
- Medical expenses
- Travel expenses (including meals and lodging)
- Home study fees
- Pre-adoptive counseling fees
- Placement fees
- Post-adoption visits by adoption agency fees
- Birth mother's living and delivery fee
- Improvements to property to accommodate an adopted disabled child

Expenses **not** covered by this program:

- Expenses for the legal adoption of step-children, biological children or grandchildren of the eligible employee or the employee's spouse
- Legal costs associated with legal guardianship
- Expenses for the biological parents, such as medical, living or counseling expenses
- Voluntary donations or contributions to the adoption agency
- Costs to obtain guardianship or custody of a child not associated with the legal adoption of the child
- Any expenses that violate state or federal law
- Costs incurred in connection with any surrogate parenting arrangement
- Costs incurred in violation of state or federal law or in carrying out any surrogate parenting arrangement
- Expenses reimbursed under another employer program or otherwise
- Any other costs not specifically covered above

Dependent Care FSA

You can set aside pre-tax dollars through salary contributions into the Dependent Care FSA. This account allows you to reimburse yourself with those tax-free salary dollars to pay for eligible dependent care expenses.

Eligible expenses are associated with the care of:

- Your children under the age of 13 for whom you or your spouse are entitled to a dependency exemption under Internal Revenue code Section 151(c). For details see IRS Publication 503 at **https://www.irs.gov/pub/irs-pdf/p503.pdf**.
- Your spouse who is physically or mentally incapable of self-care.
- A relative or household member who receives over half their support from you and is physically or mentally incapable of self-care.

How to File Claims

Optum Financial, the County's third-party administrator processes all Health, Dependent Care, and Adoption FSA claims.

Health FSA Claims

When you enroll in the Health FSA, you will be sent a debit card to ease the paperwork of filing claims. Optum Financial allows you to use their debit card instead of having to file a paper claim for healthcare expenses. The full amount you elected for your Health FSA is available on day one. Just use the Optum Financial debit card to pay healthcare expenses instead of your personal credit or debit card.

IMPORTANT: Be sure to keep all receipts for services paid with the Optum Financial debit card. Proof of your expenses may be requested by Optum Financial to verify your claim. You may also need those receipts when filing taxes.

Dependent and Adoption FSA Claims

Unlike the Health FSA, funds for your dependent care and adoption assistance expenses only become available one week after deducted from your paycheck. You can file a claim at any time, but it will not be processed and paid until you have sufficient funds in your account.

Claim Forms

Claim forms are available online on the Optum Financial website at **www.myoptumfinancial.com/alamedacounty**

Mobile Enhancement Feature: You may also download Optum Financial mobile application on your smart phone. This allows you to check your balance, review expenses, and upload receipts for claims if necessary.

Who is Eligible

Refer to your most recent Memorandum of Understanding or Appendix C to determine if you are eligible and the amount of County Allowance you can receive.

How it Works

The County provides you with a stipulated amount of money you can use to pay for certain benefits, such as Medical, Vision, Supplemental Employee Life and AD&D. This money is called the County Allowance (also referred to as Employer Credits). The County Allowance is applied to the pre-tax premiums and is not considered taxable income to you. In addition, select groups may use the County Allowance to pay into a Dependent Care and/or Adoption Assistance flexible spending account.

If you have any remaining County Allowance after you have made your pre-tax benefit elections, the first $500 goes into your Health FSA. If you do not have one, the County will set up one for you.

If there are any funds still remaining in your County Allowance after you made your pre-tax benefit elections and funds roll over to the Health FSA, you can choose to:

- Have the County match your contributions to the Health FSA up to a combined total of $3,300 (the annual maximum allowed for a Health FSA), or
- Receive the money as a taxable cash distribution to be added in equal amounts to your semi-monthly paycheck.

The following pages have examples of how this benefit works. If you have any questions, please contact the EBC for assistance in understanding all your options before making final benefit elections.

County Allowance Example

The County Allowance is a specific pre-tax dollar amount that is used to fund premiums for your Medical, Vision, and Supplemental Life/Accidental Death & Dismemberment premiums (and if eligible, your Healthcare, Dependent Care and Adoption Assistance Flexible Spending Accounts).

To access a Benefits Education Video on your **County Allowance**, scan the QR code.
CLICK HERE

County Allowance Automatic Allocations			Your Choice
1	2	3	4
Funds will be used to pay your Medical premiums (if elected). **NOTE:** For many County employees, your entire County Allowance amount will go towards Medical premiums.	Any excess funds are then used to pay your Vision premiums (if elected).	Then, any excess funds are used to pay your Supplemental Life/AD&D premiums (if elected). Any excess funds greater than $30, up to the first $500, will automatically be deposited in your Health FSA – established on your behalf.	Remaining funds greater than the $500 will automatically be cashed out as a post-tax cash disbursement throughout the year OR these funds can be used to match additional dollars you contribute through salary reduction to your Health FSA up to the $3,300 maximum for the 2026 plan year.

With this Program, the County allows you to purchase additional vacation days to enhance your work/life balance. If you are eligible, this option is available during the annual Benefits Open Enrollment period. You can get details on your vacation purchase options and costs through eBenefits during Open Enrollment.

Program Eligibility

To be eligible to participate in this Program, you must be a full-time employee.

Eligibility to purchase additional vacation during Open Enrollment is based on your Vacation Purchase plan balance as of a specific date that will be communicated each year by the EBC before Open Enrollment.

Please refer to your labor organization's current **Memorandum of Understanding** to determine eligibility and any purchasing limits for this benefit.

How to Enroll

You may purchase additional days only during Open Enrollment. The purchased days become available starting January 1 after Open Enrollment closes. For example, Open Enrollment is held during the October-November period and your purchased vacation days become available the following January 1.

If eligible, you must re-enroll each year. This benefit does not rollover from year-to-year.

You will be notified about the specific limits during each year's open enrollment. Typically, the limits on how many days you can purchase are shown below, but are subject to change.

Balance in the Fall	Eligibility to Purchase Vacation for the Next Year
5.01 or more days	You are ineligible to purchase for the next year
Less than 5 days	You may purchase one week
0 hours/days	You may purchase one or two weeks

Cost

Cost is based on your pay. Contributions towards the Program are deducted from each of your semi-monthly paychecks throughout the year on a pre-tax basis.

Vacation Purchase Benefit May Have Changed

In the past, Vacation Purchase was treated the same as taking regular accrued vacation days (excluding retirement and seniority). However, for some represented employees it was changed based on their most recent MOU, Alameda County's Salary Ordinance, and/or Administrative Code including unrepresented employees. The most recent change is that Vacation Purchase hours are subject to the same parameters as leave without pay hours. Under these circumstances, below are some very important conditions that relate to your pay and benefits when using Vacation Purchase hours.

Important Conditions that Affect this Program

Be sure to review your labor organization's current MOU, Alameda County's Salary Ordinance, and/or Administrative Code to determine what limits apply to your Vacation Purchase Benefit. Generally, these limits apply:

Medical Premiums

If you use more than 37.5 to 40 Vacation Purchase hours in a pay period, you will be responsible for the entire pay period's employee and employer-paid cost of your medical premium. You pay a pro-rated amount for the medical premiums not covered by County contributions.

Dental Premiums

If you use more than 37.5 to 40 Vacation Purchase hours in a pay period, you will be responsible for the entire pay period's employer-paid cost of the dental premium.

Leave Accruals

You will not accrue sick leave or vacation when using Vacation Purchase hours.

Retirement

The County does not make a retirement contribution when using Vacation Purchase hours.

Seniority

Vacation Purchase hours will not be counted in computing seniority.

Time Reporting

Use the time reporting code VBN when using your Vacation Purchase hours.

Holidays

You will not be eligible to receive holiday pay if you use Vacation Purchase hours the day before and/or the day after a holiday. In addition, holiday pay will be pro-rated based on the number of Vacation Purchase hours used during that pay period.

Everyone, at one time or another, experiences a problem that is difficult to handle alone. Whether the problem is your own or someone in your family, it can have an effect on everyone. This is why the County provides its employees with numerous resources for help dealing with day-to-day issues.

Employee Assistance Program

Eligibility

All employees, domestic partners, family members living at home and children registered at college away from home are eligible to take advantage of these programs. Requests to include other family members are considered on a case-by-case basis.

Available Services

The Employee Assistance Program (EAP) offered through Claremont EAP, is a pro-active, problem solving resource that provides Alameda County employees and their immediate family members with:

- Assistance for a wide variety of personal concerns
- An easy way to get help before an issue turns into a larger problem
- A positive resource that we all may need to use from time to time – it is not just a service for people with substance abuse or severe emotional issues

Alameda County EAP benefits include the following confidential services:

- **Counseling Visits**: General County of Alameda employees and family members are entitled to three free counseling visits per incident, per year. County of Alameda Public Safety Officers and family members are entitled to 10 free counseling visits per incident, per year. Visits may be used for any personal issue, such as family conflict, anxiety, depression, work stress, substance abuse and other issues that affect your quality of life. Additional visits are offered at Claremont's discounted rates.
- **Legal Services**: Legal consultations are conducted either in person or over the phone, depending on your situation and/or preference. An initial 30-minute consultation is provided at no cost to you. A 25% discount is available for any service beyond the initial consultation. Free "Simple Will" kits are also available from Claremont.
- **Financial Services**: Free consultation for virtually any financial concern, including budgeting, debt consolidation, credit report reviews, auto and real estate purchasing, retirement planning and other financial matters. Free credit reports are available upon request.
- **Dependent Care**: Nation-wide child and elder care referrals, adoption assistance, school and college assistance, pet care and consultation is provided.
- **Links to Community Resources**: Callers can be referred to an extraordinary array of community resources for personal and general health concerns in addition to their sessions with a licensed clinician. This benefit is offered on an unlimited basis.

Obtaining Assistance

Telephone calls are answered 24/7, 365 days a year by clinically trained EAP counselors. In person appointments are available with a Claremont provider. To obtain assistance call 1-800-834-3773, or visit the website at **www.claremonteap.com**.

Life Assistance Program

Eligibility

The New York Group Benefit Solutions provides the Life Assistance Program (LAP). LAP is designed to help you and your family find solutions to a variety of life challenges from parenting to financial and legal woes to achieving the right work/life balance. This program offers phone consultations, counseling referrals, online support, and community services for these challenges and more. LAP covers County employees, your household members, and beneficiaries receiving claim payments under New York Life Group Benefit Solutions. It can provide counseling services to County employees, and all members of the employee's household (whether related or not) and beneficiaries who are receiving payments under the life and accident plans.

Available Services

Advocates are available by phone to help you assess your needs, develop a solution and direct you to community and online resources. Three face-to-face sessions with a behavioral counselor are also available to you and your household members.

Here's how New York Life provides support for handling life's demands. You can call for a referral or get guidance on:

- **Legal consultation:** Receive a free 30-minute consultation and up to a 25% discount on selected fees.
- **Parenting:** Get guidance on child development, sibling rivalry, separation anxiety and more.
- **Senior care:** Learn how to solve the challenges of caring for an aging family member.
- **Pet care:** Assistance finding veterinary services, grooming and boarding.
- **Financial services and referrals:** Receive a free 30-minute consultation and 25% discount on select fees with network providers.

Obtaining Assistance

Telephone calls are answered 24/7, 365 days a year. To obtain assistance 800-344-97523 or visit the website at **https://www.guidanceresources.com/groWeb/login/login.xhtml**

No matter how far away your retirement might be, the time to start thinking about it is today. Even if your financial goals are more short-term, it is important that you carefully plan for your financial future. Depending on your eligibility, Alameda County can help you achieve your financial needs through:

- 457(b) Deferred Compensation Program
- Alameda County Employees Retirement Association (ACERA)

In addition, most County employees who are members of the retirement program are covered under Social Security.

457(b) Deferred Compensation Plan

A deferred compensation program allows you to save and invest a portion of your salary to augment your retirement income. Federal and state income taxes are deferred until your assets are withdrawn, which is usually at retirement – when you are presumably in a lower tax bracket. The Deferred Compensation Plan is designed so the assets you save today will be there for you tomorrow.

Participating in the Plan is the best way to save money for retirement years and is one of the few methods available to reduce current income taxes. Your contribution is subtracted from your pay before taxes are taken out. It is then invested in the investment options you choose.

You can also defer earnings and have them deposited into the 457(b) Roth Elective Deferred Account. These funds are after-tax dollars that can be withdrawn tax-free when you separate or retire from County employment. Please see the Roth Contributions section.

For a full description of the Plan, as well as your legal rights, the Plan sponsor's (Alameda County) duties and responsibilities, and administrative guidelines for operating the Plan be sure to read the Plan Document.

Who Is Eligible

- Permanent, full-time and part-time employees
- Project positions
- Provisional employees
- Retired annuitants and rehired employees

How to Enroll

You are eligible to participate in the Plan at any time and it is voluntary. To enroll, you must complete a Participation Agreement form and file it with the Treasurer-Tax Collector's Office, Deferred Compensation Unit. Deductions from your paycheck start as soon as administratively possible.

Contributions

Your Deferred Compensation account includes your pre-tax payroll contributions, qualified rollover contributions, and after-tax Roth contributions.

Changing your contributions. You can change your contribution amount at any time by filing a Payroll Modification form with the Treasurer-Tax Collector's Office.

- **Pre-tax Payroll Contributions**

  Once enrolled, contributions are deducted from your eligible compensation each pay period. These contributions, also referred to as **salary deferral** contributions, are deposited into your 457(b) Plan account.

  You may contribute any amount from a minimum of $20 per pay period up to an annual dollar maximum set by the IRS. The annual maximum dollar amount you elect to contribute cannot exceed the adjusted annual maximum taxable compensation for the year – including salary deferral contributions and any pretax contributions you make to other plans sponsored by the County. These salary deferral contributions are deducted from your eligible compensation before federal and state income taxes are calculated.

  The IRS determines the annual deferral maximum plus an additional amount those age 50 and older can contribute. The Treasurer-Tax Collector will send out a notification with the new annual limits. These notifications generally come out in October/November before the year the changes are effective. The Plan Document gives detailed information on deferral limits.

- **Rollover Contributions**

  You can **roll over** tax deferred funds from other qualified employer-sponsored retirement plans or from a qualified Individual Retirement Account (IRA) and retain the tax-deferred status of these funds. Your options for rollover contributions should be discussed with a qualified tax advisor or financial planner.

  Once you make a rollover contribution, these funds become subject to all provisions of this Plan. This Plan is not required to provide the same optional benefits offered under a former employer's plan.

If you have any question regarding a rollover contribution, contact the County Deferred Compensation Representative at the Treasure-Tax Collector's Office. Contact information is located in Appendix A.

- **After-Tax Roth Contributions**
  This is another type of contribution you can make into your traditional 457(b) Plan. Participants in a traditional 457(b) Plan can designate a portion or all of their contributions as after-tax Roth 457(b contributions. Roth contributions are not tax-deferred and are includible in an employee's taxable gross income subject to all withholding requirements. However, if your contributions have been in a Roth for five taxable years and you withdraw funds after age 59½, distributions of your Roth contributions, and any earnings on your Roth contributions, are not subject to taxes.
  You can elect to contribute funds designated as Roth contributions at any time. The County would then set up a separate Roth account in the Plan where the contributions would be deposited.
  For more information regarding Roth contributions, contact the County Deferred Compensation Representative at the Treasurer-Tax Collector's Office or contact Empower directly. Contact information is located in Appendix A.

Investing Your 457(b) Funds

The Deferred Compensation Program allows you to elect how to invest your accounts balances. You may invest contributions in any of the available options, in percent increments that equal 100% in total. For example, you can invest 100% in a single fund, or divide your investment among two or more funds. The investment allocation decision you make will be applied to all contributions. In addition, you may transfer assets already credited to your account between investment options at any time.

Investment choices. To learn about what investment choices you have and get information on current and historical investment performance visit the Treasurer-Tax Collector site (inter and intranet) under Deferred Compensation, Information.

Changing investment choices. You may change your investment elections for your existing account balance and future contributions at any time by contacting Empower Retirement Services or by going online to **alamedacountydcp.empower-retirement.com/participant/#/login?accu=AlamedaCounty**. Your account number is your Social Security number.

To access your account, you will need your PIN. If you do not have a PIN, call Empower Investment Services at 800-833-5761.

Vesting. The term vesting refers to your right of ownership in your account's funds. You are always 100% vested in any amounts you contribute to the Plan, as well as the earnings on those contributions. Your plan and balance statements. The Plan's assets are valued daily. Each quarter, you will receive a statement summarizing your account's activity.

You can also review your account information online at **alamedacountydcp.empower-retirement.com/participant/#/login?accu=AlamedaCounty.** To access your account, you need your PIN. If you do not have a pin, call Empower at 800-833-5761.

Withdrawals

You may withdraw from your account only when you retire from or terminate employment with the County. You must complete a Payout Request Form and submit it to the Treasurer-Tax Collector's Office within 60 days of the date you terminate employment with the County. **PLEASE NOTE:** You may not resign from the County and reinstate to withdraw funds from your account.

If you or one of your dependents suffers a catastrophic financial hardship while you are an active employee (unforeseeable emergency as defined by IRS regulations), you may be allowed to make an **in-service hardship withdrawal**. To do so, complete an Emergency Withdrawal Application Form and submit it to the Treasurer-Tax Collector's Office.

Loans

You can take a loan from your 457(b) account up to 50% of the vested account balance, to a $50,000 maximum. Shortly after you take a loan, payroll deductions for repayment will begin. You are allowed up to two outstanding loans from the Plan at a time, but you can only apply for and obtain one loan every 12 months. In other words, if you take a loan on January 10, you may not take another loan until January 10 of the next year. For more information you can contact Empower.

Rollover Distributions

If you leave the County, you can defer taxes by requesting a direct rollover to another employer's qualified plan or to an IRA. To do so, the rollover check must be made payable directly to your new employer's qualified plan or to the name of the IRA.

If the distribution is made payable to you (and not deposited into another employer's plan or to an IRA), the law requires that 20% of the amount be withheld for Federal taxes. Your actual tax liability (both Federal and state) may be more or less depending on your personal tax situation. Before making your decision, review the IRS special Tax Notice provided when your employment with Alameda County ends.

For more detailed information regarding this plan contact the Treasurer-Tax Collector's Office at 510-272-6809 or contact Empower. Contact information is located on Appendix A

Alameda County Employees Retirement Association

If you are eligible, the Alameda County Employees Retirement Association (ACERA) is another valuable component of your retirement package. This Plan provides eligible employees with a source of income during retirement. In addition, the Plan provides death benefits as well as disability compensation in the event of an approved permanent physical or mental incapacity.

Who is Eligible

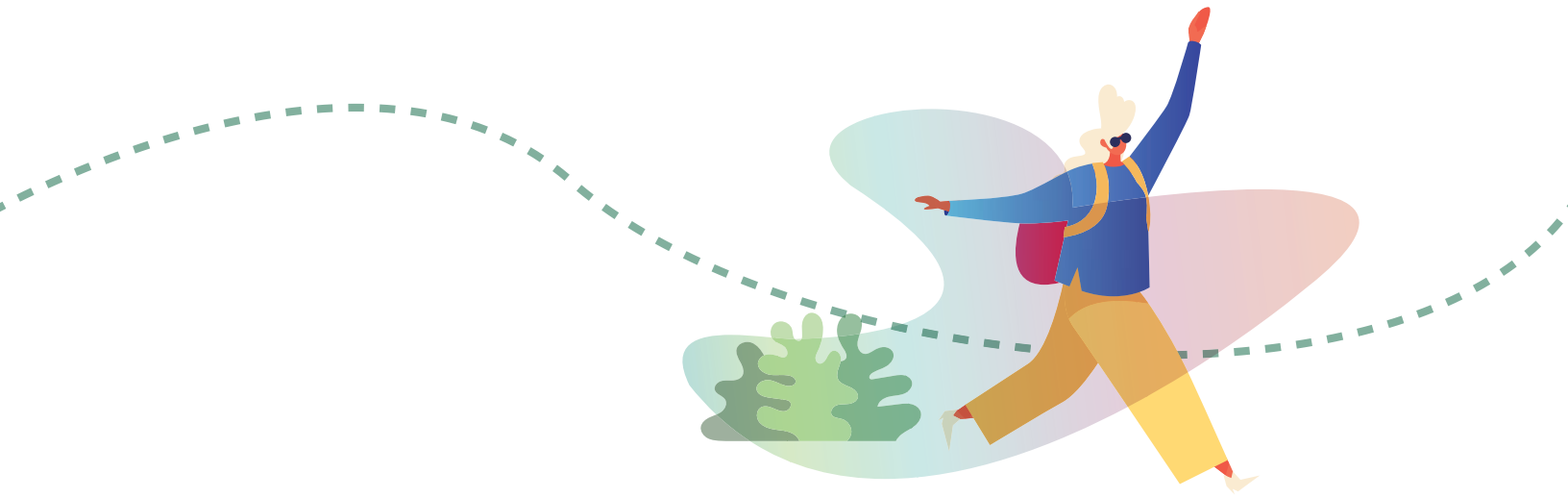
All full-time, permanent County employees are members of the Plan.

Employee contributions into the retirement system are based on age at entry into the system. Alameda County offers a four-tiered retirement system.

Membership Type	Benefit Formula
General Member – Tier I	2.62% at age 62
General Member – Tier II	2.43% at age 65
General Member – a Tier IV [hired on or after 1/1/2013]	2.50% at age 67
Safety Member – Tier IV [hired on or after 1/1/2013]	2.70% at age 57
Safety Member effective 7/3/2005	3% at age 50
Safety Member hired before 7/3/2005 [Deferred Members except for firefighters]	2% at age 50
Safety Member hired on or after 10/17/2010	2% at age 50 or 3% at age 55

Member Contributions

Your contributions are a percentage of your salary, based upon your age at your time of entry. Contributions are made on a tax-deferred basis. The '37 Act allows for reciprocity with some public sector retirement systems.



Monthly Retirement Allowances

Monthly retirement allowances are determined by three factors: age, service credit and highest average monthly salary (also called final average salary or FAS).

	Tier I	Tier II	Tier IV
General and Safety Members who	Entered ACERA on or before June 30, 1983, and have been a member continuously	Entered or re-entered ACERA between July 1, 1983 and December 31, 2012	Entered ACERA on or after January 1, 2013
Final average salary calculations based on...	Highest 26 consecutive pay periods or 12 months of pay	Highest 78 consecutive pay periods or 36 months of pay	Highest 78 consecutive pay periods or 36 months of pay
Age factors for retirement formulas increase to age...	Age 50 for Safety members Age 62 for General members	Age 50 for Safety members Age 65 for General members	Age 57 for Safety members Age 67 for General members
Eligibility for Service Retirement	Age 50 with 10 years of service or membership Includes service purchases and redeposits Does not include other public service purchase 30 years (General) or 20 years (Safety) of service at any age (including some purchased service) Age 70 – any amount of service	Age 50 with 10 years of service or membership Includes service purchases and redeposits Does not include other public service purchase 30 years (General) or 20 years (Safety) of service at any age (including some purchased service) Age 70 – any amount of service	**Tier IV General:** • Age 52 with 5 years of service • Includes service purchases and re-deposits • Does not include other public service purchase **Tier IV Safety:** • Age 50 with 5 years of service • Includes service purchases and re-deposits • Does not include other public service purchase • Age 70 – any amount of service

More Information

Information may be obtained by contacting ACERA directly. Contact information is located in Appendix A.
The ACERA office is located at:

475 14th Street, Suite 1000
Oakland, Ca 94612

More Retirement Plan Information

This information applies to both the 457(b) Deferred Compensation Program and Alameda County Employees' Retirement Association (ACERA) except as otherwise noted.

Beneficiary Designations

When you enroll in the 457(b) Deferred Compensation Program and ACERA, you will be asked to name a beneficiary(ies) for your accounts. Your named beneficiary(ies) will receive the value of your accounts in the event of your death.

Your beneficiary:

- Can be anyone you choose.
- Can be more than one individual.
- Does not have to be the same individual named in your Life Insurance benefits.
- Can be changed at any time.

IMPORTANT NOTE: If you are married, your spouse is automatically the sole beneficiary of both retirement accounts, unless your spouse consents to you naming another sole beneficiary, or more than one beneficiary. To make any beneficiary selection other than your spouse, you must obtain your spouse's consent in writing, and the consent must be notarized. If your marital status changes, please make sure you evaluate and change your beneficiary as needed.

If you die without naming a beneficiary, or you are not survived by your designated beneficiary, benefits will be paid to your surviving spouse. If you have no surviving spouse, benefits will be paid to your surviving children. If you have no surviving spouse or children, benefits will be paid to your estate.

To designate a beneficiary, complete the appropriate Beneficiary Forms —available through the Treasurer-Tax Collector's Office for the 457(b) Plan and through ACERA for Retirement.

When Your Right to Contribute to the Plan Ends

Your right to contribute to the Retirement Program ends when you:

- Retire
- No longer meet the definition of eligible employee, or
- Are no longer employed by the County.

EXCEPTION: If you become disabled and do not receive compensation from the County, or if you have been granted an unpaid leave of absence, you remain eligible to contribute to the Plan. However, you will not receive any County contributions during this time.

Plan Amendments and Termination

Although the County intends to continue these Plans indefinitely, future events cannot be foreseen. Therefore, the County reserves the right to amend or terminate the Plans at any time.

Social Security

Social Security will not replace all earnings from work, but it does provide continued income that you can build on with savings, a pension plan, investments, and other insurance.

To receive Social Security benefits, you first need credit for work under the Social Security program. The amount you can receive depends on a number of factors. Call your local Social Security office for additional information.

The County provides a wide variety of additional benefit options to help balance your work life and meet your family needs.

Alternative Child Care Assistance Program

The Alternative Child Care Assistance Program will reimburse you for child care expenses above your regular child care costs if:

- Your child cannot attend his/her regular childcare due to illness
- Your regular childcare is temporarily unavailable due to an emergency such as the illness of the provider.

The program will reimburse employees up to 90% of $80 per day in extra childcare costs incurred while you attend work as scheduled. Reimbursements are limited to $350 per year, per eligible employee. Limited funding is available — reimbursements are on a first come, first served basis. For more information on this program, please contact the Auditor-Controller Agency Staff at 510) 272-6520.

Eligibility

Employees in ACMEA represented, Local 21 PACE represented, Unrepresented and Non-management employees are eligible if they need job related childcare for at least one child under 14 years of age. Employees in ACWFIA, Local 21 ACCA, CEMU, PD, IAFF 55B and intermittent or services-as-needed personnel are excluded.

Catastrophic Sick Leave

You may be eligible to receive donations of paid leave to be included in your sick leave balance if you have suffered a catastrophic illness or injury which prevents you from being able to work, or work your regularly scheduled number of hours.

Catastrophic illness or injury is defined as a critical medical condition considered to be terminal, or a long-term major physical impairment or disability.

Eligibility

An employee is eligible to participate in the Catastrophic Sick Leave Program if they are a represented or unrepresented County employee eligible for sick leave. Check your Memorandum of Understanding for verification of applicable Catastrophic Sick Leave provisions. Employees who receive donations are referred to as the "recipient employee" in the following section.

Rules for Requesting and Receiving Catastrophic Sick Leave

- The Employee Benefits Department must receive a written request from the recipient employee, employee's family or other person designated by the employee. This request may be initiated before the date leave balances are exhausted. Request for Donation Forms are located on Alcoweb in EBC Online – Catastrophic Sick Leave.
- Mail or deliver the written request to: Employee Benefits Center, Attn: Employee Benefits Coordinator, 1405 Lakeside Drive, Oakland CA 94612; or QIC to 25701.
- The recipient employee is not eligible to receive and use donations as long as they have paid leave balances available. However, the request may be initiated prior to the anticipated date that leave balances will be exhausted.
- A confidential medical verification including diagnosis, prognosis, and estimated date of return to work is required by the recipient employee's attending physician and submitted to the Employee Benefits Department. A Return to Work Certificate is available for this purpose, and is located on Alcoweb, in EBC Online under Other Employee Programs—Catastrophic Sick Leave.
- The determination of the employee's eligibility for catastrophic sick leave donations is at the County's sole discretion. The County's decision will be final and non-grievable.
- A recipient employee is eligible to receive 180 working days of donated time per employment period.
- Employees may donate unlimited amounts of time, in full-day increments of 7.5 or 8 hours, unless otherwise specified by the donor's MOU. **EXCEPTION:** Spouses/registered domestic partners who both work for the County may donate unlimited amounts of time between one another.
- The donor employee may donate their vacation time, compensatory time, or in lieu holiday time to be converted to the recipient employee's sick leave balance. All sick leave provisions to the donated time apply to the recipient.
- Donated time in any pay period may be used in subsequent pay periods. Retroactive donations are not permitted.
- Donation Authorization Forms are located on Alcoweb, in EBC Online under Other Employee Programs – Catastrophic Sick Leave.
- The donor's hourly value will be converted to the recipient's hourly value and then added to the recipient's sick leave balance on a dollar-for-dollar basis.

- The recipient employee's entitlement to personal disability leave will be reduced by the number of hours added to their sick leave balance.
- Recipient employees able to work, but working less than their regular schedule, will integrate catastrophic sick leave donations with time worked and their own paid leave. Recipient employee's own paid leave must be used first.
- Donations of time and/or any disability leave will be integrated so that the recipient employee will not exceed 100% of their gross salary.
- For all forms or questions regarding the County's Catastrophic Sick Leave Policy, please see EBC Online under Other Employee Programs found on Alcoweb; or you may call the Employee Benefits Center at 510-891-8953 and speak with the CSL Administrative Specialist.

Commuter Benefit Plan

The Commuter Benefit Plan allows you to set aside before-tax dollars to pay mass transit and parking expenses related to commuting to and from work. When spent on an eligible commuting expense, every dollar of the earnings you set aside is tax-free. The County of Alameda has partnered with WEX Inc. to administer this plan.

Eligibility

Full- and part-time employees including services as needed and temporary assignment pool are eligible for the Commuter Benefit. EXCEPTIONS: Retired Annuitants, Judges and EBCRC are not eligible.

How to Enroll

You can obtain a paper enrollment form on the EBC Online website under Forms. Complete the enrollment form and then submit it to the EBC either by QIC, email or fax. Typically, deductions will start the first paycheck of the following month but can be later depending on when you submit the form. Once you are enrolled, you can make changes to your deductions at any time by submitting a new enrollment form.

Once you enroll and payroll deductions start, it takes approximately 10 business days from your paycheck date for the monies to be available in your WEX Benefits Account. You can log onto WEX at **https://www.wexinc.com/login/benefits-login/** and track the funds in your account.

Your payroll deductions will be loaded to a WEX Visa Debit Card to be used for your Commuter expenses.

Qualified Transportation Expenses

Mass transportation – Qualified mass transportation expenses can be a token, fare card or any item entitling a person to transportation on a mass transit facility such as, but not limited to, BART, MUNI, and AC Transit.

Other transportation –The WEX Visa Debit Card can be added as a payment method in the Uber and Lyft apps. Commuter dollars can be used toward Uber POOL and Lyft Line rides in select cities.

A commuter highway vehicle qualifies as a van pooling alternative. This is a vehicle with seating capacity of six or more adults (not including the driver) and if at least 80% of the annual mileage age is for transporting employees between their residence and employer. Typically, a fee is charged for commuting in a van pool and is considered a reimbursable expense.

Parking – Qualified parking expenses can be parking provided on or near the County's business premises or a location from which you commute by car, bus or train. If you park at a mass transportation commuter lot, you use your WEX Visa Debit Card or submit a claim for reimbursement for eligible expenses for both parking and mass transportation.

Accessing Funds

You can use your WEX Visa Debit Card to pay at the time of service. If a transit or parking facility doesn't accept debit card payments, you can pay out-of-pocket and submit a reimbursement request through the WEX Mobile App by WEX or on your online account.

Sign up for direct deposit to receive your reimbursement as quickly as possible.

Additional Features

To take full advantage of the program, it is important to know these important features:

- Pre-tax deductions are allowed up to $340/month for transit and $340/month for parking.

- If you terminate employment from the County, you have a run-out period to claim expenses. Reimbursement will only be for the period you were an active employee during the run-out period, and any services incurred after your date of termination are not qualified expenses and will not be reimbursed. For cash reimbursement of qualified parking expenses, you have 180 days from the date of termination to claim your reimbursement.

If you have questions regarding the WEX Inc. website, how it works and/or products offered, contact WEX directly at 866-451-3399. For questions regarding eligibility, contact the EBC.

Guaranteed Ride Home

The Alameda County CMA Guaranteed Ride Home Program is a free benefit that guarantees a ride home from work when unexpected circumstances arise. You can feel confident commuting to work when you know you will have a ride home in case of an emergency.

You may take a Guaranteed Ride Home if:

- You or an immediate family member suffers from an unexpected illness or severe crisis
- You must work unscheduled overtime (supervisor authorization is required)
- Your ridesharing vehicle breaks down or the driver has to stay late or leave early, or
- You have walked, bicycled, carpooled, vanpooled, or taken the ferry, bus or train on the day the Guaranteed Ride Home voucher is used

This benefit cannot be used for personal errands, pre-planned medical appointments, ambulance services, business-related travel, anticipated overtime or working overtime without a supervisor's request, or non-emergency side trips on the way home.

When using Guaranteed Ride Home, emergency-related stops on your way home are permissible.

Eligibility

Anyone that works for Alameda County and commutes to work.

How to Enroll

Complete the easy employee online registration by visiting the website at **http://grh.alamedactc.org/register/**

How it Works

All you need to do is register online at the Guaranteed Ride Home website.

This is a reimbursement program. The program reimburses you for your qualified out-of-pocket expenses within the Program parameters. To receive reimbursement, go online to the GRH website and complete an online form and upload your receipts. Or, you can download a paper expense reimbursement form and submit your receipts through the postal system.

REMEMBER: You must be registered to receive reimbursement and you must register annually to maintain this valuable benefit.

Rental Car vs. Taxi

To make this program as cost-effective as possible, we need as many people as possible to use an Enterprise rental car. However, follow these guidelines for which transportation mode is most appropriate for you.

Take a RENTAL CAR if all of the following apply:

- Your trip distance is 20 miles or more.
- You need a ride for reasons other than personal illness or crisis.
- You are able to drive, feel comfortable driving, and have a valid California driver's license.
- You are requesting a ride during Enterprise business hours.
- You will be able to meet Enterprise's vehicle return requirements.

Take a TAXI if your trip distance is less than 20 miles or you do not meet the rental car criteria.

Critical Illness, Accident and Hospital Plans

Accidents, hospital stays and catastrophic illnesses can occur at any time and can be very expensive. MetLife offers three optional plans you can purchase to protect your or your family's financial future. Each plan pays a cash benefit for certain injuries and illnesses to reimburse part of your everyday expenses or help pay medical bills.

Eligibility

Alameda County employees who are regularly scheduled to work at least 50% of their classification standard hours.
EXCEPTIONS: Temporary and services as needed employees are not eligible.

How to Enroll

Complete enrollment through your eBenefits enrollment portal during Open Enrollment.

Critical Illness Plan

Critical Illness coverage from MetLife pays a lump sum amount to members with certain critical diagnoses, including cancer, COVID-19, renal failure or the need for a heart bypass. This list also includes lupus, multiple sclerosis, severe burn, muscular dystrophy, spina bifida, and sickle cell anemia. If any of these occur, you receive a lump sum payment up to the amount of your coverage, dependent upon certain prognosis and treatment criteria. This lump sum is in addition to the benefits you may receive with your medical insurance already. Please keep these items in mind about the MetLife Coverage:

- The $50 Health Screening Benefit includes eligible tests, including COVID-19 testing to make it easier to receive the benefit.
- Under MetLife, you can purchase coverage up to $50,000 in $10,000 increments.

Plan Enhancements for 2026

- Coverage for Autism Spectrum Disorder
- New Skin Cancer Benefit
- Coverage for infectious and Childhood Diseases

Accident Plan

This plan provides a cash benefit when you have a hospital or intensive care confinement for a variety of occurrences, such as dismemberment, dislocation, fractures, physical therapy and more. It also includes transportation by ambulance. There are two plan options both costing the same amount. For details, go to the MetLife information site at **www.metlife.com/coa** or call 800-438-6388.

Hospital Indemnity

You can choose from two plan options that provide a cash benefit when you have a hospital and intensive care confinement. For details, go to the MetLife information site at **www.metlife.com/coa** or call 800-438-6388.

Plan Enhancements for 2026

- Admission Benefit increased from 1x to 4x per year
- Increased Newborn Nursery Benefit
- Increase in Patient Rehab Benefit (Low Plan)
- Removed Mental Health and Substance Abuse exclusionss

Identity and Fraud Protection powered by Aura

Helps keep you and your loved ones safe from financial and identity fraud with a suite of digital security features. Plans include access to credit and bank account monitoring, VPN security and more.

Trustmark Life/Long Term Care Protection:

Trustmark Life/Long Term Care Protection:
Should you need extended medical care due to chronic illness or disability, this coverage can help pay for the cost associated with long term care services. Life Coverage ensures that your beneficiaries will receive a death benefit whenever it is needed, providing peace of mind that your loved ones will be taken care of financially. Flexible premiums and Cash Value - you can adjust your premiums and death benefit amounts to align with your financial goals and changing needs.

There are two different plans to choose, designed with features to meet a wide range of benefit and cost needs for employees and dependents age 18-64 - with guaranteed issue of coverage (no medical underwriting) up to $150,000 for employees hired on or after Jan 1, 2025. Employees hired before Jan 1, 2025 can still apply for coverage but will be subject to medical underwriting approval. Additional amounts up to $300,000 are available with medical underwriting. For employees age 65-75, there is a coverage option that does require medical underwriting.

If you are interested in enrolling or just learning more about this program, Trustmark has its own seperate enrollment platform. Please visit **https://trustmark.benselect.com/alameda**.

Group Legal Insurance

This plan entitles you and your eligible dependents to certain personal legal services through the MetLife Legal Plan. Available benefits are comprehensive, as long as certain limits and other conditions are met.

The plan has no deductibles, no copays and no claim forms when using a MetLife Legal Plan network attorney.

Please take the time to read the detailed description of benefits located on the EBC Online website, before you decide to enroll in this plan. For more information on MetLife Legal Plan coverage visit **info.legalplans.com** and enter code 9900345 or by calling 800-821-6400.

Eligibility

Alameda County employees who are regularly scheduled to work at least 50% of their standard hours.

EXCEPTIONS: Temporary and services as needed employees are not eligible. If eligible, all benefits are available to you and your spouse and dependents.

The **MetLife Legal Plan** covers you, your spouse and dependents for a wide range of legal matters with no deductibles, no co-pays, no claim forms or usage limits when using a Network Attorney for a covered matter. The new **MetLife Legal Plan Plus Parents** option covers your parents and parents-in-law too for estate planning, identity theft issues, document review and more.

Enrollment and Cost

Once you enroll in the MetLife legal plan you are locked in for the entire plan year and will not be able to drop or change coverage until the next open enrollment period.

	MetLife Legal Plan	MetLife Legal Plan Plus Parents
Cost per Pay Period	$8.25	$11.25

What is Covered

Here is a list of services provided to members, spouses and family members. All bolded services are also available to parents or parents-in-law if enrolled in the MetLife Plus Parents plan.

MetLife Legal Plan Plus Parents for County of Alameda

Money Matters	• **Life Stages – Identity Management Services**[1] • Personal Bankruptcy • Negotiations with Creditors	• Financial Education Workshops[3] • Tax Audit Representation • Identity Theft Defense	• **Promissory Notes** • Debt Collection Defense • Tax Collection Defense
Home & Real Estate	• Foreclosure • Tenant Negotiations • Boundary & Title Disputes • **Deeds** • **Mortgages**	• Sale or Purchase of Primary and Vacation Home • Eviction Defense • Property Tax Assessments	• Refinancing & Home Equity Loan of Primary and Vacation Home • Security Deposit Assistance • Zoning Applications
Estate Planning	• **Simple Wills** • **Complex Wills** • Revocable & Irrevocable Trusts	• **Powers of Attorney (Healthcare, Financial, Childcare, Immigration)**	• **Healthcare Proxies** • **Living Wills** • **Codicils**
Family & Personal	• Adoption • Guardianship • Conservatorship • Prenuptial Agreement • Name Change • **Review of ANY Personal Legal Document**	• Juvenile Court Defense Including Criminal Matters • Parental Responsibility Matters • School Hearings • **Demand Letters** • Personal Property Issues	• **Affidavits** • Garnishment Defense • Protection from Domestic Violence • Review of Immigration Documents • Divorce (20 hours)
Civil Lawsuits	• Civil Litigation Defense • Disputes Over Consumer Goods & Services	• Small Claims Assistance • Administrative Hearings	• Incompetency Defense • Pet Liabilities
Elder-Care Issues	**Consultation & Document Review for issues related to your parents** • **Medicare** • **Medicaid**	• **Prescription Plans** • **Nursing Home Agreements** • **Leases** • **Notes**	• **Deeds** • **Wills** • **Powers of Attorney**
Vehicle & Driving	• Repossession • Defense of Traffic Tickets[2]	• Driving Privileges Restoration	• License Suspension Due to DUI

MetLife Legal Plan is AFFORDABLE through Payroll Deductions

All services above cover Member, Spouse and Dependents; All Bolded services are also available to Parents

[1] This benefit provides the Participant with access to LifeStages Identity Management Services provided by CyberScout, LLC. CyberScout is not a corporate affiliate of MetLife Legal Plan.

[2] Does not cover DUI.

[3] MetLife administers PlanSmart's Retirewise program which provides these workshops but has arranged for Massachusetts Mutual Life Insurance Company (MassMutual) to have specially-trained financial professionals offer financial education and, upon request, provide personal guidance to employees and former employees of companies providing this program through MetLife.

Nationwide Group Pet Insurance

Nationwide Pet Insurance provides Individual insurance policies for veterinary services to cover your dog, cat or other qualifying pet. The plan offers options for coverage up to 80%, options for deductibles from $100 -$500 and options for annual benefit maximums up to $5000.

Eligibility

Alameda County employees who are regularly scheduled to work at least 50% of their standard hours. **Exceptions:** Temporary and services as needed employees are not eligible.

How to Enroll

Go to www.petinsurance.com/alameda for enrollment information.

What is Covered

This plan covers office visits, accidents, illnesses emergencies, surgeries, hospitalization, X-rays, labs, and medications. If you have any questions about coverage contact Nationwide customer service at 800-540-2016 or go to their website at www.petinsurance.com/alameda.

Pre-Existing Conditions

Any pre-existing condition your pet has before enrollment in Nationwide will not be covered.

Cost

To get a quote, go to www.petinsurance.com/alameda.
Discounts are available for multi-pet policies.
are the starting costs for pets:

MetLife Group Pet Insurance

More than ever, pets play a huge role in our lives, and we want to do everything we can to keep them safe and healthy. **A small monthly payment can help you prepare for those unexpected veterinarian expenses down the road.** MetLife Pet Insurance provides Individual insurance policies for veterinary services to cover your dog, cat or other pets. With MetLife Pet Insurance, you may be able to receive reimbursement of up to 100% of covered veterinary care expenses. And you can visit any licensed vet or emergency clinic in the U.S.

Eligibility

Alameda County employees who are regularly scheduled to work at least 50% of their standard hours. **Exceptions:** Temporary and services as needed employees are not eligible.

How to Enroll

To get a quote or enroll, visit www.metlife.com/getpetquote.

What is Covered

This plan covers office visits, accidents, illnesses, emergencies, surgeries, hospitalization, X-rays, labs, and medications.
If you have any questions about coverage contact MetLife customer service at 1-800-GET-MET8 or go to their website at www.metlife.com/getpetquote.

Pre-Existing Conditions

Any pre-existing condition your pet has before enrollment in MetLife will not be covered.

Cost

Costs vary by age of pet and other variables. To get a quote, go to www.metlife.com/getpetquote.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is Federal legislation that requires all employers who sponsor a group health plan to offer an opportunity to extend health coverage after an employee or their covered dependent no longer qualifies for healthcare insurance.

Although the County is mandated to offer COBRA coverage due to certain qualifying events (defined below), it is your option to accept the coverage or not. If you accept COBRA coverage, you are responsible for paying the entire cost which is the group rate plus a 2% administration fee.

NOTE: If you lose coverage through the County, other healthcare options may be available to you at a lower cost than COBRA continuation coverage. For information, contact the Health Insurance Marketplace at 800-318-2596 or visit their website at **www.HealthCare.gov**. Additional information on other information will also be provided when you lose your coverage.

Who is Eligible

Any employee, spouse/domestic partner or other covered family member who loses County-sponsored group coverage due to a qualifying event, is eligible to elect continuation of coverage.

Qualifying Events

- A qualifying event is the loss of group coverage due to:
- Reduction in hours
- Termination of employment (except gross misconduct)
- Death
- Spouse's enrollment in Medicare Part A and/or B
- Divorce or legal separation
- Loss of dependent status

COBRA Notification

The County sends a COBRA notice to all employees at the time of initial benefits eligibility – either at hire or through a job promotion. However, the plan administrator must be notified when certain qualifying events occur such as a legal separation or divorce.

Once a qualifying event occurs and the plan administrator is notified, those affected will receive notification on the availability of COBRA Continuation Coverage. The recipients of the notification then have 60 days to elect COBRA coverage. The election period starts at the later of the date of the qualifying event or the date the election notice is provided.

For more information regarding COBRA benefits, contact the EBC at 510-891-8991.

How to Enroll

The COBRA notification will include details on how to enroll, when your enrollment election is due to the administrator, the cost, where to send your premium payments, and the length of time that you may continue your coverage. Subject to certain limitations you may elect to continue your medical, dental and vision plan at your own expense.

Generally, COBRA coverage may continue for up to 36 months under a combination of Federal and State (CalCOBRA) benefit continuation laws. For more information on CalCOBRA, contact the insurance carrier directly.

Kaiser Permanente	https://my.kp.org/alamedacounty	(800) 464-4000
UnitedHealthcare	www.whyuhc.com/alameda	(800) 624-8822
Delta Dental PPO	https://www.deltadentalins.com/coa	(888) 335-8227
DeltaCare USA	https://www.deltadentalins.com/coa	(800) 422-4234
Vision Service Plan (VSP)	https://countyofalameda.vspforme.com	(800) 877-7195
Operating Engineers Health Plan	https://www.oe3publichealth.org	(800) 251-5014
Flexible Spending Accounts (FSA)	https://www.optumfinancial.com	(877) 292-4040
MetLife Critical Illness, Accident, Hospital, Legal Plan, Pet Insurance	https://www.metlife.com/coa	(800) 438-6388
Commuter Benefits	https://www.wexinc.com	(866) 451-3399 (833) 225-5939
Nationwide	https://www.petinsurance.com/alameda	(800) 540-2016
Met Life Identity and Fraud Protection powered by Aura	https://www.metlife.com/identity-and-fraud-protection	(844) 931-2872
Trustmark Long Term Care Protection	https://ACLTCenrollment.com	(833) 465-2464
New York Life Insurance	myNYLGBS.com	(888) 842-4462 or (866) 562-8421 (español), 7:00 am – 7:00 pm CST

These acronyms may be used in this Benefits Handbook and in other communications from the EBC.

This Acronym:	Stands For:
ACCA	Alameda County Counsel Association
ACERA	Alameda County Employees' Retirement Association
ACMEA	Alameda County Management Employees Association
ACPA	Alameda County Prosecutor's Association
ACWFIA	Alameda County Welfare Fraud Investigators Association
AD&D	Accidental Death and Dismemberment
BTC	Building and Construction Trades
CEMU	Civil Engineers Management Unit
CI	Critical Illness
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCAP	Dependent Care Assistance Program
DSA	Deputy Sheriffs Association
EAP and LAP	Employee Assistance Program and Life Assistance Program
EOB	Explanation of Benefits
EOC or COC	Evidence of Coverage or Certificate of Coverage
EOI	Evidence of Insurability (Medical Underwriting)
EBC	Employee Benefits Center
FMLA	Family and Medical Leave Act
FSC	Family Status Change
HIPAA	Health insurance Portability and Accountability Act
HMO	Health Maintenance Organization
IFPTE	International Federation of Professional and Technical Engineers
IRA	Individual Retirement Account
IRS	Internal Revenue Service
LTD	Long-term Disability
MHN	Managed Health Network
MOU	Memorandum of Understanding
OE3	Operating Engineers Local Union No. 3
PACE	Professional Association of County Employees
PCP	Primary Care Physician
PPO	Preferred Provider Organization
PPOA	Probation Peace Officers' Association
QMCSO	Qualified Medical Child Support Order
RFL	Return from Leave
SEIU	Service Employees International Union
SAN	Services As Needed
SDI	State Disability Insurance
STD	Short-term Disability
TAP	Temporary Assignment Pool
UAPD	Union of American Physicians and Dentists

County Allowance Flexible Spending Accounts

These schedules show the annual amount each Eligible Group is entitled to receive in the annual County Allowance (also known as the Annual Employer Credit) and the three Flexible Spending Accounts

NOTE: All groups listed are eligible for Premium Conversion.

Management Groups

	County Allowance	Health FSA	Dependent Care FSA	Adoption Assistance FSA
ACCA	$3,500	$3,300	$7,500	$6,00
ACMEA DA Inspectors	$3,500	$3,300	$7,500	$6,000
ACMEA General & Confidential	$3,600	$3,300	$7,500	$6,000
ACMEA Sheriffs Sworn	$3,100	$3,300	$7,500	$6,000
ACMEA Sheriffs Non-Sworn	$3,600	$3,300	$7,500	$6,000
ACMEA Probation Management	$3,200	$3,300	$7,500	$6,000
ACPA - DA	$3,500	$3,300	$7,500	$6,000
ACWFIA	$3,500	$3,300	$7,500	$6,000
CEMU	$3,500	$3,300	$7,500	$6,000
PACE	$3,500	$3,300	$7,500	$6,000
Public Defender	$3,500	$3,300	$7,500	$6,000
Unrepresented Management	$3,600	$3,300	$7,500	$6,000
Superior Court Judges	$1,500	$3,300	$7,500	None

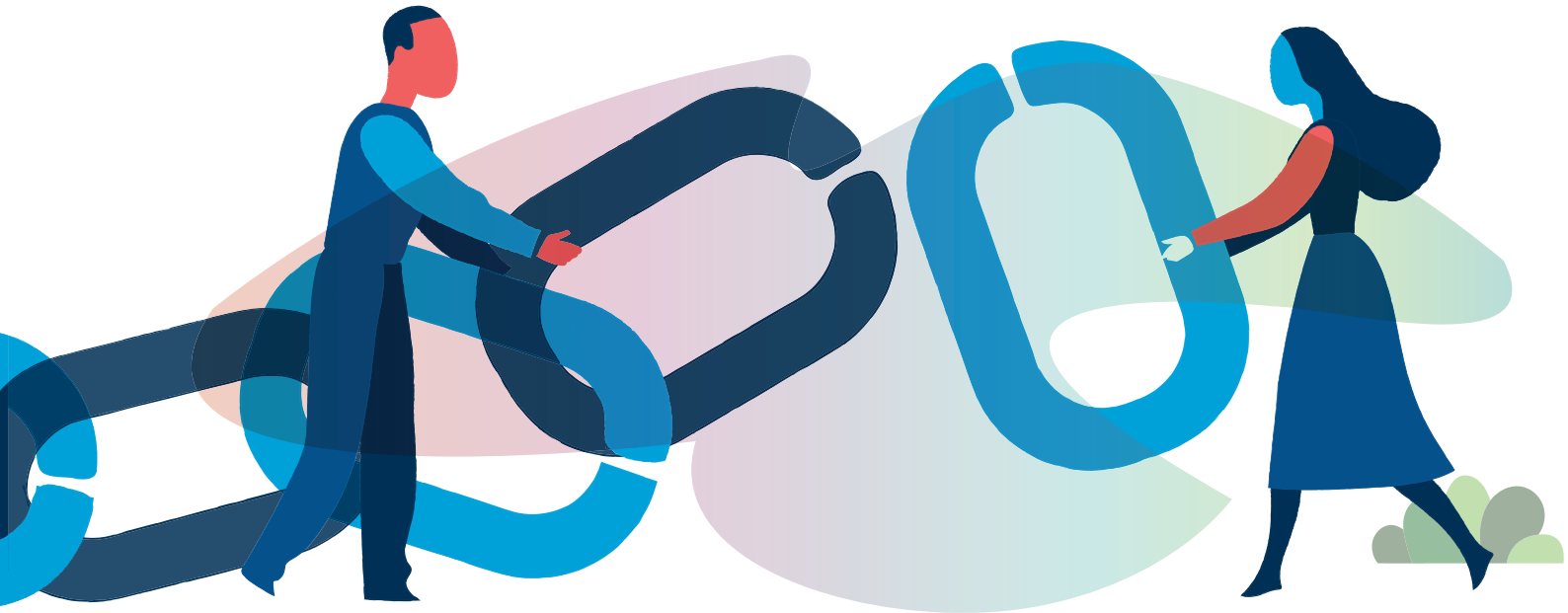
Non-Management Groups

	County Allowance	Health FSA	Dependent Care FSA	Adoption Assistance FSA
BTC	$1,300	$3,300	$7,500	None
DSA	$1,200	$3,300	$7,500	None
IFPTE Local 21 Engineer 016, 060, 077	$1,400	$3,300	$7,500	None
PPOA	$1,200	$3,300	$7,500	$6,000
SEIU 1021 includes Zone 7	$1,200	$3,300	$7,500	None
Teamsters Local 856	$1,200	$3,300	$7,500	$6,000
UAPD Non SAN	$1,300	$3,300	$7,500	$6,000
UAPD SAN	None	$3,300	$7,500	None
Unrepresented Non-Management	$1,200	$3,300	$7,500	None

Medical Plans

The County provides all eligible employees with a choice of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans. All plans cover medical expenses incurred for non-occupational illness or accidental injury. Coverage also includes mental health, substance abuse services and more.

The County offers five medical plan options. When you choose a plan for yourself, you can enroll your eligible dependents in the same plan.

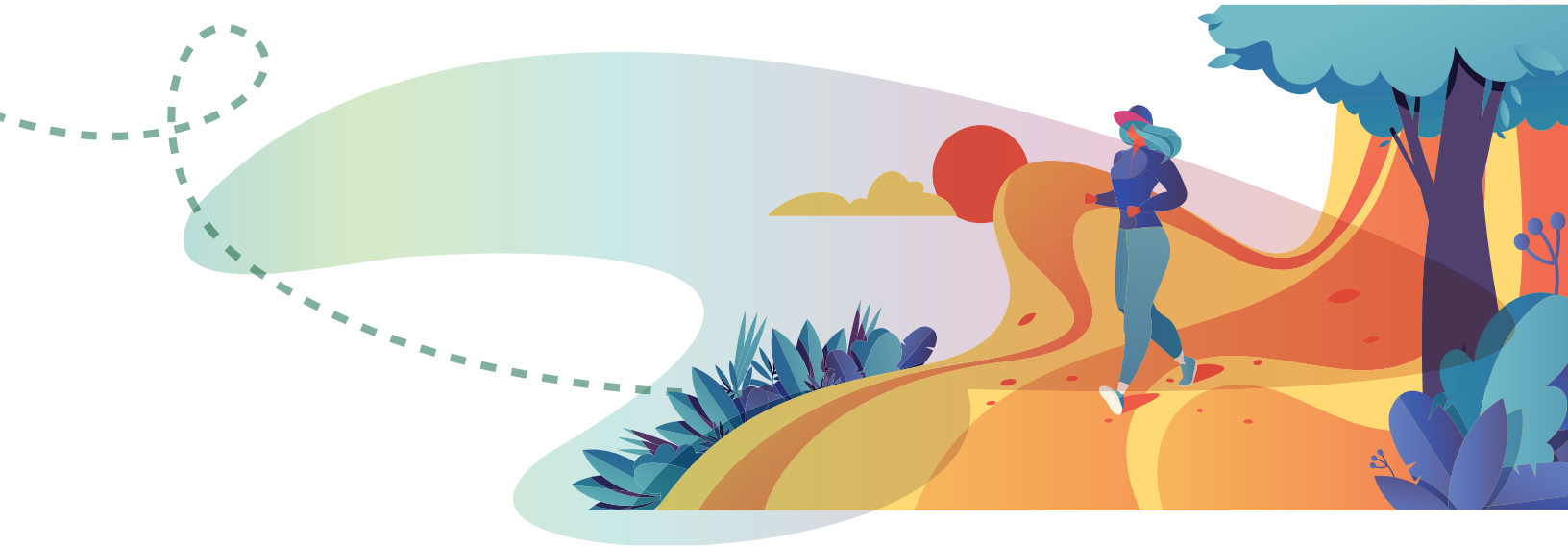


Your Cost

When you work standard hours, your contribution amount for medical coverage depends on the plan you select, the number of family members you cover, and your Bargaining Unit. Each rate table shows the semi-monthly cost and how you and the County share the cost of your medical coverage

You can access videos, tools, and resources on our New Employee Benefits Showcase, an On Demand resource for all County employees.

88%	12%	**Group 1 – County pays 88% and Employee pays 12%** **Participating: SEIU, and Unrepresented Non-Management** **(semi-monthly contributions)**			
Plan		**Self**	**Self + 1**	**Family**	**Change**
Kaiser $15 County contribution Employee contribution		$473.77 $64.60	$947.53 $129.21	$1,340.76 $182.83	+3.28% Increase
Kaiser $40 County contribution Employee contribution		$440.29 $60.04	$880.58 $120.08	$1,246.03 $169.91	+3.28% Increase
UHC SignatureValue $15 County contribution Employee contribution		$809.77 $110.42	$1,620.09 $220.92	$2,292.67 $312.64	+15.43% Increase
UHC SignatureValue $40 County contribution Employee contribution		$724.03 $98.73	$1,447.52 $197.39	$2,048.75 $279.38	+15.43% Increase
UHC Select Plus PPO County contribution Employee contribution		$473.77 $427.33	$947.53 $854.70	$1,340.76 $1,209.35	+30.67% Increase



85%	15%	**Group 2 – County pays 85% and Employee pays 15%** **Participating: ACCA, ACPA, ACMEA General & Conf., ACMEA DA Inspectors, ACMEA Sheriff's Sworn, ACMEA Sheriff's Non-Sworn, ACMEA Probation Mgt., ACWFIA, BTC, CEMU, DSA,, IFPTE (016, 060, 077) , PACE, PPOA, Public Defender Chpt., Teamsters, UAPD, and Unrep. Management (semi-monthly contributions)**			
Plan		**Self**	**Self + 1**	**Family**	**Change**
Kaiser $15 County contribution Employee contribution		$457.61 $80.76	$915.23 $161.51	$1,295.05 $228.54	+3.28% Increase
Kaiser $40 County contribution Employee contribution		$425.28 $75.05	$850.56 $150.10	$1,203.55 $212.39	+3.28% Increase
UHC SignatureValue $15 County contribution Employee contribution		$782.16 $138.03	$1,564.86 $276.15	$2,214.51 $390.80	+15.43% Increase
UHC SignatureValue $40 County contribution Employee contribution		$699.35 $123.41	$1,398.17 $246.74	$1,978.91 $349.22	+15.43% Increase
UHC Select Plus PPO County contribution Employee contribution		$457.61 $443.49	$915.23 $887.00	$1,295.05 $1,255.06	+30.67% Increase

2026 Operating Engineers Local 3 Medical Plans – Available to Building and Construction Trades Council Employees

Enrolling in an Operating Engineers Local 3 (OE#3) plan **requires a two-step process for your enrollment to be complete.** During the Annual Open Enrollment, complete the County enrollment through eBenefits and next complete an Operating Engineers paper enrollment form and submit to the Employee Benefits Center by the close of Open Enrollment on November 10, 2025. If you become eligible mid year and would like to enroll in this plan, you are required to complete a Personal Enrollment Form and an Operating Engineers paper enrollment Form. You are required to return both forms within 30 days of your eligibility date.

- STEP 1 Enroll online during Open Enrollment. If midyear, complete a Personal Enrollment Form **and**
- STEP 2 Submit an Operating Engineers paper enrollment form – You may print this form from EBC online or request a copy from the EBC

REMEMBER – To make any change in the OE#3 plans – change from one plan to another or add/remove dependent—be sure to complete both enrollments as discussed above.

If you elect an OE#3 plan, you cannot be enrolled in the County's Dental plan. You may however enroll in the County's Vision Plan.

If you re-enroll in the County's Medical Plan, please remember to also enroll in the County's Dental and Vision Plans.
Current participants who want to continue existing coverage do not need to enroll in eBenefits or complete any forms.

To receive detailed information and pricing for the Operating Engineers plans, please email Mike McCall, Director of Benefits at **mmccall@oe3publichealth.org**.

Dental Plans

The semi-monthly premiums below show the amount the County pays for dental coverage for you and your family. Employees pay nothing.**

Plan	Self	Self +1	Family
Delta Dental PPO	$28.56	$52.76	$82.61
Delta Dental PPO Supplemental Plan	$9.65	$18.33	$27.92
DeltaCare USA DHMO	$14.43	$24.39	$37.39

**If you work fewer than the standard hours in a given pay period, the County contribution may be reduced. In the event you are on a leave without pay for more than 5 days, 100% of the cost will be your responsibility either through paycheck deduction or through the benefit billing process.

Vision Plans

Employees pay the full cost of coverage on a semi-monthly basis.

Plan	Self	Self +1	Family
Vision Choice Plus	$3.99	$8.01	$12.58
Vision Choice Premium	$10.14	$19.24	$28.57

Basic Life Insurance

100% paid by the County. The County pays $0.04 per $1,000 of coverage.

Voluntary Insurance Plans

IF YOU ENROLL, YOU PAY 100% OF THE COST.

Employee Supplemental Life

Age as of January 1, 2026	Cost per $1,000 of Coverage
Less than age 30	$0.030
Age 30 thru 34	$0.036
Age 35 thru 39	$0.049
Age 40 thru 44	$0.070
Age 45 thru 49	$0.117
Age 50 thru 54	$0.187
Age 55 thru 59	$0.299
Age 60 thru 64	$0.402
Age 65 thru 69	$0.617
Age 70 and over	$1.082

Disability

Cost per $100 of Base Salary

Age as of January 1, 2026	Short-Term Disability	Long-Term Disability
Less than age 25	$0.934	$0.097
Age 25 thru 29	$0.958	$0.114
Age 30 thru 34	$0.962	$0.157
Age 35 thru 39	$0.699	$0.229
Age 40 thru 44	$0.570	$0.401
Age 45 thru 49	$0.620	$0.649
Age 50 thru 54	$0.735	$0.878
Age 55 thru 59	$0.849	$1.038
Age 60 thru 64	$0.956	$1.023
Age 65 and over	$1.048	$0.926

Management Options

- Child Supplemental Life: $0.141 per $1,000
- Spouse Supplemental Life: Same cost as Employee Supplemental Life, based on spouse's age
- AD&D for Employee: Only $0.02 per $1,000
- AD&D for Employee and Family: $0.03 per $1,000

Please take the time to read these frequently asked questions and the answers. This section was developed using actual employee questions handled by the EBC. If you have a question or issue not addressed here, call the EBC at 510-891-8991, email us at emailEBC@acgov.org, or send us a chat at https://ebc-chatbot.acgov.org.

Health Care

Q: My spouse and I both work for the County and we want to enroll our family in medical coverage. Can we both choose the family medical?

A: Yes. However, you need to choose coverage through different carriers (Kaiser and UnitedHealthcare) to ensure your elections do not result in duplicate coverage for you or any of your covered dependents.

Q: If both my spouse and I work for the County, Do I have to choose the same coverage levels for medical and dental?

A: No. For example, you could choose Family coverage for medical but choose to cover only yourself for dental. However, you should not both choose Family coverage.

Q: If I work less than 50% of my standard hours in a pay period, what happens to my Share-the- Savings stipend, my medical premiums and dental coverage?

A: If you work less than 50% of the standard hours for your job classification you are not eligible to receive the Share-the Savings stipend.

Through pro-ration you are also responsible for up to 100% of both the medical and dental premiums. These premiums are automatically deducted from your pay check. If there is insufficient pay to cover the premiums, a billing statement will be sent to your home address to request payment of the outstanding premiums. If not paid by the date on the billing statement, the medical and/or dental coverage will be canceled retroactively.

Q: Do the medical plans have pre-existing condition clauses?

A: No. Our healthcare plans have no pre-existing condition limits.

Q: If I am on a leave of absence or leave without pay, and currently not covered under any County-sponsored medical and/or dental plan, can I enroll during Open Enrollment?

A: No. However, you will have an opportunity to enroll within 30 days of your return to work as long as you contact the EBC. If you do not contact the EBC within the 30-day election period, your next opportunity will be the following Open Enrollment.

Q: Do I get a Share-the-Savings stipend if I waive dental coverage?

A: No. The stipend is available only when reducing a tier level or waiving medical coverage.

Q: What happens if I do not provide proof of alternative medical coverage when electing Share-the-Savings Plan?

A: You must certify alternate coverage every year during the Open Enrollment period. If you do not provide the EBC with proof of alternative medical coverage by the communicated deadline, there are two consequences:

- You and/or your eligible dependents will not be enrolled in the Share-the-Savings Plan for the coming plan year and the stipend will not be added to your pay, and
- You will not be enrolled in a County-sponsored medical plan.

Q: Are over-the-counter drugs covered under my health FSA?

A: Yes. Over-the counter drug purchases are a reimbursable expense through your health FSA as a result of changes in the law made by the CARES Act in 2020.

Dental Coverage

Q: I enrolled in the Delta Care USA plan and covered my wife, a County employee. Can my wife enroll in the Delta Dental PPO Supplemental Plan and cover me?

A: No. The Delta Dental PPO Supplemental Plan is not a stand-alone plan. The Delta Dental PPO Supplemental Plan is a supplement to the Delta Dental PPO Plan. You could choose to enroll in the Delta Dental PPO Plan and cover your wife. Your wife can then enroll in the Delta Dental PPO Supplemental Plan and cover you. This way, the dental benefits will coordinate.

Vision Coverage

Q: How do I find out if I am eligible for vision coverage?

A: The benefits you are eligible to enroll in will be listed when you log onto online eBenefits or receive a paper enrollment form. You can also call the EBC and speak with an Employee Benefits Technician.

Dependent Coverage

Q: What happens if I do not submit my supporting documentation?

A: The EBC must receive applicable forms and supporting documentation by the EBC communicated deadline. If not, your dependent(s) will be removed from your coverage.

Q: If I drop coverage for my dependents during Open Enrollment, are they eligible to continue coverage under COBRA?

A: No. Dropping a dependent (spouse/domestic partner and/or child) during Open Enrollment is not considered a COBRA Qualifying Event.

Q: My dependents are in college and living away from home at times during the year. What things should I consider?

A: If your dependent lives away from home at times during the year, check your medical and/or dental plan options to see what provider access is available to him/her. You will find plan contact information in Appendix A of this Handbook.

NOTE: Dependents not residing within the carrier's service area are only eligible for urgent/emergency services. It's a good idea to schedule your student's medical and dental appointments when home on a school holiday.

Kaiser Permanente members can now visit the nearest MinuteClinic and pay their standard coinsurance or copay if they get sick or injured while traveling in a state where Kaiser Permanente does not operate. All that is needed is a photo ID and their membership card or health/medical record number.

MinuteClinics are located in select CVS Pharmacy and Target locations. They are staffed by non-Kaiser Permanente nurse practitioners and physician assistants who can treat a range of simple urgent care services for conditions and symptoms. Members can visit a MinuteClinic with or without an appointment. The MinuteClinic gives Kaiser Permanente members one more convenient alternative for urgent (non-emergency) care, including: Away from Home Travel Line (951-268-3900), **kp.org/travel**, and early refill of eligible prescriptions.

Q: Can I add my young adult dependent to my benefit plan?

A: Yes. You may cover your young adult dependents until they reach age 26. Complete your enrollment online through eBenefits, during Open Enrollment. Then submit your supporting documentation to the EBC by the EBC communicated deadlines. Any other time during the year you must either be newly eligible or have a qualifying event.

Q: How long do I have to add my young adult dependent up to age 26 to my benefit plan?

A: Add your young adult dependent up to age 26 during the Open Enrollment Period. If you add them during this time in eBenefits, this ensures the accuracy of your enrollment. Any other time during the year you, or they, must either be newly eligible or have a qualifying event.

Life and AD&D Insurance

Q: Who is eligible to purchase Supplemental Life and AD&D insurance coverage?

A: Coverage becomes effective in the month two consecutive deductions can be taken from your paycheck. You must be actively at work at the County on the day your coverage takes effect. See Disability Plans for details.

Q: Can I purchase Supplemental Life or AD&D coverage for my spouse/domestic partner and eligible dependent children without buying it for myself?

A: No. You need to buy coverage for yourself to be eligible to buy it for your spouse/domestic partner and children.

Q: If both my spouse/domestic partner and I work for the County, can we cover one another on our Supplemental Life Insurance plans? Can we both cover our children?

A: No. Duplicate coverage between spouse/domestic partner and dependents is not allowed.

Q: When does the IRS consider my Supplemental Employee Life Insurance benefit subject to imputed income tax?

A: If your total Basic Life and Supplement Employee Life insurance benefit is over $50,000, you are subject to imputed income tax by the IRS. Imputed income is the value the IRS assumes you would have to pay to purchase a similar policy in the private market, based on your age and the amount of coverage you have. The IRS considers this value to be income, and as such, requires the County to add the income value associated with the benefit coverage over $50,000 to your pay for tax purposes. The additional taxes you owe as a result are withheld from your paycheck.

Q: What is the difference between a Primary and a Contingent beneficiary for life insurance purposes?

A: A primary beneficiary is the person who will be paid in the event of a life insurance claim. A Contingent beneficiary is the person who will receive your Life benefit in case your Primary beneficiary is deceased. Note: You may designate more than one Primary and more than one Contingent beneficiary.

Disability Coverage

Q: If I enroll in STD and LTD, when is the coverage effective?

A: Coverage becomes effective in the month two consecutive deductions can be taken from your paycheck. You must be actively at work at the County on the day your coverage takes effect. See **Disability Plans** for details.

Q: If I am currently enrolled, do I have to re-enroll during Open Enrollment.

A: If you are already enrolled in the STD and/or LTD plan your enrollment will continue into the new plan year.

Q: How long do I have to wait before I can receive my STD benefits?

A: Once you are approved for benefits, you will be eligible to collect STD benefits starting on the eighth day following the date your disability begins. To be eligible to receive STD payments, your disability must be a non-work related injury or illness.

Q: If I am disabled, can the amount of my benefit be reduced?

A: Yes. Benefits may be reduced by other income you receive. Check the STD and/or LTD Benefits Highlights Sheet located on the EBC online website for details.

Q: How long do I have before I can receive my LTD Benefits?

A: You must be disabled for at least 180 days before you are eligible to receive a Long-Term Disability Insurance benefit payment.

Q: Under LTD, how long will my disability payments continue?

A: For as long as you are certified disabled, or until you reach your Social Security Normal Retirement Age, whichever is sooner. If your disability occurs at or over age 65, the duration of your benefits will be reduced. Please read the Certificate of Coverage located on the EBC Online website for details.

Q: How do I drop my STD and/or LTD benefit?

A: During Open Enrollment you can waive your coverage in the online eBenefits system. Any other time of the year, contact the EBC to obtain a Termination Form you must complete and return.

Health Flexible Spending Account

Q: Can I use the Health FSA for my own health care expenses and for my dependents' eligible expenses, too?

A: Yes. You can use the Health FSA to reimburse yourself for eligible out-of-pocket health care expenses incurred by yourself, your spouse/domestic partner, your children or young adult dependent. Eligible expenses are defined by the IRS and are those specified in the plan that would generally qualify for the IRS medical and dental expenses tax deduction. These are explained in IRS Publication 502.

NOTE: You cannot receive a payment from your Health FSA for these expenses:

- Amounts paid for medical, dental or vision insurance premiums
- Amounts paid for disability insurance premiums
- Amounts paid for long-term care coverage or expenses
- Amounts that are covered under another health plan

Q: What determines the dollar amount in my Health FSA?

A: If you are eligible for a County Allowance (see **County Allowance** for eligibility) your Health FSA is calculated based on the amount of your County Allowance less the cost for some benefits (Medical, Vision, Employee Supplement Life, and AD&D), plus any salary you contribute to your Health FSA.

Q: What happens to my left over funds if I leave the County?

A: Any expenses incurred after your termination date are not reimbursable. Any expenses incurred prior to your termination date have a 90 day runout period. You will have 90 days from your termination date to submit your claim for reimbursement.

Adoption Assistance Flexible Spending Account

Q: I plan on adopting a child. How can the Adoption Assistance FSA assist me?

A: You can set aside pre-tax dollars for qualified adoption expenses you pay to adopt a child. This lowers your taxable gross income so you pay fewer taxes.

Q: Where can I find out more information on how the Adoption Assistance FSA works?

A: Go to the EBC Online website, under "Healthcare & Insurance Benefits," then "Evidence of Coverage Booklets." There you can find the "Cafeteria Plan Document" which contains an entire section on how the Adoption Assistance FSA works. In addition, you should consult with your personal tax adviser.

Dependent Care FSA

Q: Who are my eligible dependents for Dependent Care FSA reimbursement purposes?

A: You may use your Dependent Care FSA contributions to reimburse yourself for the eligible expenses associated with the care of:

- Your children under the age of 13 for whom you or your spouse are entitled to a dependency exemption under Internal Revenue code Section 151(c)
- Your spouse who is physically or mentally incapable of self-care
- A relative or household member who receives over half of their support from you and is physically or mentally incapable of self-care.

Q: What types of expenses can be reimbursed through the Dependent Care FSA?

A: You can use the Dependent Care FSA to reimburse yourself for expenses associated with the care of an eligible dependent, provided the care is required in order for you (and your spouse, if married) to work. Eligible expenses may include payments you make to a licensed provider for childcare, or for payments made to an organization or qualified individual to provide in-home care to an adult dependent. Refer to the Internal Revenue code Section 151(c) for further information.

Vacation Purchase Plan

Q: Can I purchase only a few days of extra vacation?

A: No. Additional vacation can only be purchased in one- or two-week increments.

Q: Do I have to pay for purchased vacation time before I use it?

A: No. The County takes your vacation purchase deductions in equal increments over the year, so you will not finish paying for your vacation purchase election until the end of the year in which the deductions started. If an adjustment needs to be made, then the County has the right to adjust your future deductions or possibly take a lump sum. However, you may use your purchased vacation any time after January 1, subject to work demands and your supervisor's approval.

Q: Are vacation purchase deductions pre-tax?

A: Yes.

Q: What happens if I am unable to pay for purchased vacation time?

A: The County has a right to reduce the purchased vacation balanced hours.

Q: What if I voluntarily terminate employment with the County before paying for my purchased vacation-used or unused?

A: If you terminate employment with the County and have used your purchased vacation time before paying for it in full, you will be required to make up the difference. The County will deduct the balance you owe from your final paycheck. If your final paycheck is insufficient, you must repay the County with your own money. If your vacation purchase went unused, the County will refund the amount previously deducted from your pay on a post-tax basis.

Q: Do my vacation purchase payments continue if I am on a non-paid leave of absence?

A: No. While on a non-paid leave of absence, the County does not collect money for your vacation purchase election. Once you return to work, the County has the right to adjust your future deductions or possibly take a lump sum. The County will require you to pay the balance if you are still on a non-paid leave of absence at the end of the year.

Q: Does Vacation Purchase time count toward retirement service credit?

A: No.

Commuter Benefits Plan

Q: How can I save money with this program?

A: You are not required to pay income, Social Security or FICA taxes on money used to pay your commuting expenses. By electing to have your commuting costs deducted from your paycheck on a pre-tax basis, you can save up to 40% on your commute!

Q: What other benefits does it provide?

A: This benefit offers a Visa card to conveniently pay your parking and transit expenses.

Q: What expenses are not included in this program?

A: Under the law, mileage, tolls, fuel, and carpooling are not part of this program. Business travel and other reimbursed expenses are also excluded from this benefit.

Q: How do I enroll in the plan?

A: Enrollment in this benefit is open all year. You can enroll by completing a Commuter Benefits Payroll Deduction Worksheet. Once completed, submit the worksheet to EBC for processing.

Q: Is there cash reimbursement on the transit?

A: You can submit a claim online with WEX Inc., for any out-of-pocket expenses you incur for parking and transit.

APPENDIX F – PRO-RATION OF COUNTY CONTRIBUTION WHEN WORKING LESS THAN STANDARD HOURS

BACK TO TOC

Standard hours for most classifications within Alameda County are 75 hours in each pay period. One pay period is two weeks. For some classifications, the standard hours are 80 for each pay period.

When a benefit eligible employee works fewer than the standard hours for their classification in a pay period, the County may pro-rate (reduce) its contribution toward Medical, Dental and the Share-the-Savings stipend.

Any employee who works less than 50% of the standards hours for their classification in a pay period may be responsible for 100% of the medical and dental premiums for that pay period.

These additional premiums will be deducted from your pay. If premiums cannot be deducted, a bill will be sent to your home. If the premiums are not paid, coverage will be terminated retroactively to the first of that month.

You cannot change or cancel your Medical and Dental plans until the next annual Open Enrollment unless you experience a qualifying event.

This example shows the amount you pay for **Medical** and **Share-the-Savings** when you are on leave:

If you are on leave without pay for:	The County pays:	You pay:
1 Day	90%	10%
2 Days	80%	20%
3 Days	70%	30%
4 Days	60%	40%
5 Days	50%	50%
More than 5.1 days	0%	100%

Pro-ration for Dental: If you work fewer than the standard hours in a given pay period, the County contribution may be reduced. In the event you are on a leave without pay for more than 5 days, 100% of the cost shifts to you.

Administrative Documents

This section provides you with information about the Plan Documents, Discretionary Authorities, and the confines in which benefits are offered for Alameda County.

If you need further information or assistance on benefit matters, contact the Employee Benefits Center at 510-891-8991.

Plan Documents

The benefit plan descriptions contained in this Benefits Handbook summarize the main features of the County's benefits program, and are not intended to amend, modify or expand the provisions of the Plan Document. If a conflict arises between a statement in this Benefits Handbook and the Provisions of the plan document, evidence of coverage, master insurance contract or trust agreement, the plan document, evidence of coverage, master insurance contract or trust agreement will govern.

Discretionary Authority of Plan Administrator

In carrying out their responsibilities, the County and the Plan Administrator have the discretionary authority to interpret the terms of the plans and to determine the eligibility for benefit payments. Any interpretation or determination made by such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation was arbitrary and capricious.

Plan Future

While Alameda County intends to continue these plans, it reserves the right, through its Board of Supervisors to terminate, suspend, withdraw, amend, or modify the plans and/or policies (including altering the amount you must pay for any of these benefits) in writing, in whole or in part, at any time. Any such action is subject to the applicable provisions of the plan document; however, if a plan is terminated, it will not affect any claim made when it was in force.

Either the policyholder (the County) or the carrier can cancel coverage by giving 31 days written notice. If the County terminates coverage with any of the plans, you may be able to convert your group coverage(s) to an individual policy(ies); however, certain restrictions and limitations may apply.

Disclosure Form Part One

COUNTY OF ALAMEDA
CID 29 ($15 Plan)
Chiro/Acu $15/30 visits
Home Region: Northern California
2/1/26 through 1/31/27

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge
Physician Specialist Visits by interactive video or telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Services and Care	You Pay
Emergency department visits	$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service	$15 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	$15 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$15 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

(continues)

Disclosure Form Part One *(continued)*

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Services, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

6000.283.1.S000785749

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California

2026 Disclosure Form Amendment for Combined Chiropractic and Acupuncture Services

This document amends your Kaiser Foundation Health Plan, Inc. *Disclosure Form* to add coverage for Combined Chiropractic and Acupuncture Services.

July 24, 2025

Your Kaiser Permanente Combined Chiropractic and Acupuncture Benefit

Benefit Highlights

Professional Services (ASH Participating Provider office visits)	You Pay
Chiropractic and acupuncture office visits (up to a combined total of 30 visits per 12-month period)	$15 per visit

Other	You Pay
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*.

Introduction

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH Participating Providers available to you. When you need chiropractic care or acupuncture, you have direct access to more than 3,000 licensed chiropractors and more than 2,900 licensed acupuncturists in California.

In addition to the terms defined in the "Definitions" section of your *Disclosure Form*, some capitalized terms have special meaning in this document, as described in the "Definitions" section at the end of this document.

This amendment is only a summary of your chiropractic and acupuncture coverage. The Chiropractic and Acupuncture Services Amendment to your *EOC* provides details about the terms and conditions of your chiropractic and acupuncture coverage, including exclusions and limitations.

To obtain the amendment to your *EOC* please contact your group.

ASH Participating Providers

The list of ASH Participating Providers is available on the ASH Plans Website at **ashlink.com/ash/kp** or from the ASH Plans Customer Service Department at **1-800-678-9133** (TTY users call 711) weekdays, hours may vary. The list of ASH Participating Providers is subject to change at any time without notice.

How to Obtain Services

You can obtain services from any ASH Participating Providers without a referral from a Plan Physician.

To obtain services, call an ASH Participating Provider to schedule an initial examination. If additional Services are required after the initial examination, verification that the Services are Medically Necessary may be required. Your ASH Participating Provider will request any required medical necessity determinations. An ASH Plans' clinician in the same or similar specialty as the provider of Services under review will determine whether the Services are or were Medically Necessary Services. For more information about how to obtain covered Services, refer to the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*.

Second Opinions

You may request a second opinion in regard to covered Service by contacting another ASH Participating Provider. Your visit to another ASH Participating Provider for a second opinion generally will count toward any visit limit, if applicable. An ASH Participating Provider may also request a second opinion in regard to covered Services by referring you to another ASH Participating Provider in the same or similar specialty. If you are referred by an ASH Participating Provider to another ASH Participating Provider, or see an ASH Participating Provider for lab work or an X-ray, your visit to the other ASH Participating Provider will not count toward any visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described in your Health Plan *EOC*.

Your Costs

When you receive covered Services, you must pay the Cost Share as described in the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*. The Cost Share does not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum described in the Health Plan *EOC*.

ASH Plans Customer Service

If you have question about the Services you can get from an ASH Participating Provider, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary.

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage under the Combined Chiropractic and Acupuncture Services amendment. (Note: Some items and services listed in this “Exclusions” section may be covered Services under your Health Plan *EOC*. Please refer to your Health Plan *EOC* for details.) These exclusions apply to all Services that would otherwise be covered under the Combined Chiropractic and Acupuncture Services amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Acupuncture services for conditions other than Musculoskeletal and Related Disorders, nausea, and pain
- Acupuncture performed with reusable needles
- Services provided by an acupuncturist that are not within the scope of licensure for an acupuncturist licensed in California
- For Acupuncture Services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under “Chiropractic Supports and Appliances” in the “Covered Services” section of this Amendment
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If coverage for a Service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *EOC* for information about the appeal process

- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of this Amendment
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions and appropriate adjunctive therapies, such as hot/cold packs, infrared heat, or acupressure, when provided during the same course of treatment and in conjunction with acupuncture and when provided by an acupuncturist for the treatment of your Musculoskeletal and Related Disorder, nausea (such as nausea related to chemotherapy, post-surgery nausea, or nausea related to pregnancy), or joint pain (such as lower back, shoulder, or hip joint pain), and headaches.

ASH Participating Provider: One of the following types of providers:

- An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide Medically Necessary Acupuncture Services to you
- A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you

A list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage Members, or **ashlink.com/ash/kp** for all other Members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or

skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions.

Treatment Plan: One of the following, depending on whether the Treatment Plan is for Chiropractic Services or Acupuncture Services:

- The course of treatment for your Musculoskeletal or Related Disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments), and adjunctive therapies that are Medically Necessary Chiropractic Services for you
- The course of treatment for your Musculoskeletal or Related Disorder, nausea, or pain, which will include a specific number of visits for acupuncture (including adjunctive therapies) that are Medically Necessary Acupuncture Services for you

Disclosure Form Part One

COUNTY OF ALAMEDA
CID 29 ($40 Plan)
Chiro/Acu $20/30 visits
Home Region: Northern California
2/1/26 through 1/31/27

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$40 per visit
Most Physician Specialist Visits	$40 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$40 per visit
Most physical, occupational, and speech therapy	$40 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge
Physician Specialist Visits by interactive video or telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$40 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission

Emergency Services and Care	You Pay
Emergency department visits	$100 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service	$15 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	$30 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$40 per visit
Group outpatient mental health treatment	$20 per visit

(continues)

Disclosure Form Part One *(continued)*

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$500 per admission
Individual outpatient substance use disorder evaluation and treatment	$40 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per calendar year)	$500 per admission
Prosthetic and orthotic devices as described in the *EOC*	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Services, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

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KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California

2026 Disclosure Form Amendment for Combined Chiropractic and Acupuncture Services

This document amends your Kaiser Foundation Health Plan, Inc. *Disclosure Form* to add coverage for Combined Chiropractic and Acupuncture Services.

July 24, 2025

Your Kaiser Permanente Combined Chiropractic and Acupuncture Benefit

Benefit Highlights

Professional Services (ASH Participating Provider office visits)	You Pay
Chiropractic and acupuncture office visits (up to a combined total of 30 visits per 12-month period)	$20 per visit

Other	You Pay
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*.

Introduction

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH Participating Providers available to you. When you need chiropractic care or acupuncture, you have direct access to more than 3,000 licensed chiropractors and more than 2,900 licensed acupuncturists in California.

In addition to the terms defined in the "Definitions" section of your *Disclosure Form*, some capitalized terms have special meaning in this document, as described in the "Definitions" section at the end of this document.

This amendment is only a summary of your chiropractic and acupuncture coverage. The Chiropractic and Acupuncture Services Amendment to your *EOC* provides details about the terms and conditions of your chiropractic and acupuncture coverage, including exclusions and limitations.

To obtain the amendment to your *EOC* please contact your group.

ASH Participating Providers

The list of ASH Participating Providers is available on the ASH Plans Website at **ashlink.com/ash/kp** or from the ASH Plans Customer Service Department at **1-800-678-9133** (TTY users call 711) weekdays, hours may vary. The list of ASH Participating Providers is subject to change at any time without notice.

How to Obtain Services

You can obtain services from any ASH Participating Providers without a referral from a Plan Physician.

To obtain services, call an ASH Participating Provider to schedule an initial examination. If additional Services are required after the initial examination, verification that the Services are Medically Necessary may be required. Your ASH Participating Provider will request any required medical necessity determinations. An ASH Plans' clinician in the same or similar specialty as the provider of Services under review will determine whether the Services are or were Medically Necessary Services. For more information about how to obtain covered Services, refer to the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*.

Second Opinions

You may request a second opinion in regard to covered Service by contacting another ASH Participating Provider. Your visit to another ASH Participating Provider for a second opinion generally will count toward any visit limit, if applicable. An ASH Participating Provider may also request a second opinion in regard to covered Services by referring you to another ASH Participating Provider in the same or similar specialty. If you are referred by an ASH Participating Provider to another ASH Participating Provider, or see an ASH Participating Provider for lab work or an X-ray, your visit to the other ASH Participating Provider will not count toward any visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described in your Health Plan *EOC*.

Your Costs

When you receive covered Services, you must pay the Cost Share as described in the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*. The Cost Share does not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum described in the Health Plan *EOC*.

ASH Plans Customer Service

If you have question about the Services you can get from an ASH Participating Provider, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary.

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage under the Combined Chiropractic and Acupuncture Services amendment. (Note: Some items and services listed in this “Exclusions” section may be covered Services under your Health Plan *EOC*. Please refer to your Health Plan *EOC* for details.) These exclusions apply to all Services that would otherwise be covered under the Combined Chiropractic and Acupuncture Services amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Acupuncture services for conditions other than Musculoskeletal and Related Disorders, nausea, and pain
- Acupuncture performed with reusable needles
- Services provided by an acupuncturist that are not within the scope of licensure for an acupuncturist licensed in California
- For Acupuncture Services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under “Chiropractic Supports and Appliances” in the “Covered Services” section of this Amendment
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If coverage for a Service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *EOC* for information about the appeal process

- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of this Amendment
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions and appropriate adjunctive therapies, such as hot/cold packs, infrared heat, or acupressure, when provided during the same course of treatment and in conjunction with acupuncture and when provided by an acupuncturist for the treatment of your Musculoskeletal and Related Disorder, nausea (such as nausea related to chemotherapy, post-surgery nausea, or nausea related to pregnancy), or joint pain (such as lower back, shoulder, or hip joint pain), and headaches.

ASH Participating Provider: One of the following types of providers:

- An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide Medically Necessary Acupuncture Services to you
- A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you

A list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage Members, or **ashlink.com/ash/kp** for all other Members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or

skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions.

Treatment Plan: One of the following, depending on whether the Treatment Plan is for Chiropractic Services or Acupuncture Services:

- The course of treatment for your Musculoskeletal or Related Disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments), and adjunctive therapies that are Medically Necessary Chiropractic Services for you
- The course of treatment for your Musculoskeletal or Related Disorder, nausea, or pain, which will include a specific number of visits for acupuncture (including adjunctive therapies) that are Medically Necessary Acupuncture Services for you

COUNTY OF ALAMEDA – PREMIUM PLAN

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits

15/0%

These services in the table below are covered as indicated when authorized through your Primary Care Physician in your Network Medical Group.

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health, and prescription drug and acupuncture benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health, and prescription drugs and acupuncture benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Individual Out-of-Pocket Limit. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	Individual: $1,500 Family: $3,000
PCP Office Visits/Telehealth Services	$15 Office Visit Co-payment
Specialist Office Visits/Telehealth Services (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$15 Office Visit Co-payment
Hospital Benefits	No charge
Emergency Services	$50 Co-payment Co-payment waived if admitted
Urgently Needed Services Urgent care services – services provided **within** the geographic area served by your medical group Urgent care services – services provided **outside** of the geographic area served by your medical group Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	$15 Co-payment $50 Co-payment

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	No charge
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Hospital Benefits	No charge
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	No charge
Maternity Care Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	No charge
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.** Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs.	No charge
Newborn Care The inpatient hospital benefits Co-payment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.	No charge
Physician Care (physician fees)	No charge
Reconstructive Surgery	No charge
Rehabilitation and Habilitative Care (Including physical, occupational and speech therapy)	No charge
Skilled Nursing Facility Care (Up to 100 days per benefit period)	No charge
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.** Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs.	No charge
Termination of Pregnancy (Medical/medication and surgical)	No charge

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $15 Office Visit Co-payment $15 Office Visit Co-payment
Ambulance (Only one ambulance Co-payment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Co-payment)	No charge
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply) Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	$15 Co-payment
Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days. Additional Co-payment for office visits may apply.)	No charge
Dialysis (Additional Co-payment for office visits may apply)	$15 Co-payment per treatment
Durable Medical Equipment Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children who are covered until at least the end of the month in which Member turns 19 years of age.)	No charge
Hearing Aid - Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	No charge
Hearing Aid – Bone Anchored Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered. Bone-anchored hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone-anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Hearing Exam PCP Office Visit Specialist Office Visit Co-payments for audiologist and podiatrist visits will be the same as for the PCP. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	 $15 Office Visit Co-payment $15 Office Visit Co-payment
Home Health Care Visits (Up to 100 visits per calendar year)	No charge
Home Test Kits for Sexually Transmitted Diseases	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this Schedule of Benefits
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services **If your employer group has purchased this benefit, please refer to your infertility rider for additional information**	Not covered
Infusion Therapy Infusion Therapy is a separate Co-payment in addition to a home health care of an office visit Co-payment. Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Injectable Drugs (Co-payment/Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Co-payment/Coinsurance may also apply) Outpatient Injectable Medication Self-Injectable Medication Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	$50 Co-payment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group) (Additional Co-payment for office visits may apply)	No charge

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Maternity Care, Tests and Procedures PCP Office Visit Specialist Office Visit Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	 No charge No charge
Mental Health Care Services Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing, facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental Disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, and psychiatric observation. Intensive Behavioral Therapy Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs. Schoolsite Outpatient Mental Health Care Services are covered without deductible, Co-insurance, Co-payment, or any other cost sharing requirement. **(Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)**	 $15 Office Visit Co-payment No charge No charge
Oral Surgery Services	No charge
Outpatient Habilitative Services and Outpatient Therapy	$15 Office Visit Co-payment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$15 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
Physician Care – office visits PCP Office Visit/Telehealth Services Specialist Office Visit/Telehealth Services	 $15 Office Visit Co-payment $15 Office Visit Co-payment

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Preventive Care Services (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Health Care Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	No charge
Prosthetics and Corrective Appliances Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Co-payment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Co-payment amount if any) Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge No charge
Radiology Services Standard: (Additional Co-payment for office visits may apply) Specialized Scanning and Imaging Procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure. Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge No charge

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Substance Related and Addictive Disorder Services Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management	No charge
All Other Outpatient Treatment includes, but are not limited to: Partial Hospitalization/ Day Treatment, High Intensity Outpatient, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment	No charge
Intensive Behavioral Therapy	No charge
Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs. Schoolsite Outpatient Substance Related and Addictive Disorders Services are covered without deductible, Co-insurance, Co-payment, or any other cost sharing requirement. **Please refer to your the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	
Termination of Pregnancy (Medical/medication and surgical) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are NOT defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	No charge
Vasectomy	No charge
Virtual Care Services Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling Customer Service at the telephone number on your ID card.	$15 Co-payment
Vision Refractions	$15 Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the Allowed Amount, or the Recognized Amount as applicable, which is defined in the Evidence of Coverage.

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Network Benefits for Covered Health Care Services provided by a Network Provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at Network facilities on a non-Emergency basis at which, or as a result of which, services are received from out-of-Network Providers***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible. You shall pay no more than the same cost sharing than you would pay for the same Covered Health Care Services received from a Network Provider.

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below,*** you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Combined Evidence of Coverage and Disclosure Form.*
- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Combined Evidence of Coverage and Disclosure Form.*
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Combined Evidence of Coverage and Disclosure Form*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the *Combined Evidence of Coverage and Disclosure Form*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service A*ct with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible.

For Air Ambulance transportation provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

For Emergency ground ambulance transportation provided by an out-of-Network provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

each of the above-noted benefits is covered when authorized by your Participating Medical Group or UnitedHealthcare, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE or other services provided by Out-of-Network Providers as described above. A Utilization Review Committee may review the request for services.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT AND THE UNITEDHEALTHCARE OF CALIFORNIA COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND ADDITIONAL BENEFIT MATERIALS MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT THE UNITEDHEALTHCARE OFFICE AND YOUR EMPLOYER'S PERSONNEL OFFICE. UNITEDHEALTHCARE'S MOST RECENT AUDITED FINANCIAL INFORMATION IS ALSO AVAILABLE UPON REQUEST.

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

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Effective: 2/1/2026

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COUNTY OF ALAMEDA – PREMIUM PLAN

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

Pharmacy Schedule of Benefits

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's Tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at **www.myuhc.com** or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization participation or activation requirements associated with such programs by contacting us at **www.myuhc.com** or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications, including FDA-approved contraceptive drugs, devices and products available when prescribed by a Network provider. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at **www.myuhc.com** or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower Tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Variable Co-payment Program**: Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact **www.myuhc.com** or the telephone number on your ID card for an available list of Prescription Drug Products and the applicable Co-payment and/or Co-insurance. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at **www.myuhc.com** or the telephone number on your ID card. **NOTE:** The Tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's Tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its Tier placement. Please contact us at **www.myuhc.com** or the telephone number on your ID card for the most up-to-date Tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications. A 12-month supply of $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives. This includes all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved, contraceptive drugs, devices, and products available over-the-counter. Contraceptives for women from a Network pharmacy include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel. This also includes the following: • If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, at least one will be covered without cost-sharing or medical management restrictions. If there is no therapeutic equivalent generic substitute available in the market, the brand name contraceptive will be covered without cost-sharing or medical management restrictions. • All FDA-approved contraceptives will be covered without cost-sharing or medical management restrictions when deemed Medically Necessary by the prescriber.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's Tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, or Tier 2, or Tier 3. Please contact us at **www.myuhc.com** or the telephone number on your ID card to find out Tier status. For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 2 Prescription Drug Product: $25 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 3 Prescription Drug Product: $35 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
• Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices and products will be provided at Network pharmacies without cost sharing or medical management restrictions. A prescription will not be required to trigger coverage of these products. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. All cost sharing applies to the Out-of-Pocket Limit.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drug Products. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 31-day supply with three refills.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's Tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, or Tier 2, or Tier 3. Please contact us at **www.myuhc.com** or the telephone number on your ID card to find out Tier status. For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $20 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 2 Prescription Drug Product: $50 per Prescription Order or Refill

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
	Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 3 Prescription Drug Product: $70 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. All cost sharing applies to the Out-of-Pocket Limit.

This *Schedule of Benefits* provides specific details about your Prescription Drug Product benefit, as well as the exclusions and limitations. Together this document and the *Supplement to the Combined Evidence of Coverage and Disclosure Form* as well as the medical *Combined Evidence of Coverage and Disclosure Form* determine the exact terms and conditions of your Prescription Drug Product coverage.

What do I Pay When I fill a Prescription?

The amount you pay for any of the following under this Pharmacy *Schedule of Benefits* will not be included in calculating any Out-of-Pocket Limit stated in your medical Schedule of Benefits:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates will not be available to you.

For Prescription Drug Products at a Network Retail pharmacy, you will pay the lower of the applicable Co-payment for a Prescription Unit, or the Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from mail order, you are responsible for paying the lower of either the applicable Co-payment or a Network Pharmacy's retail price for the Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Network Pharmacy. Your Co-payments are as shown in the grid above.

NOTE: The Tier status of a prescription drug can change periodically. Tier status changes resulting in higher Co-payments occur four times per calendar year or Contract Year. We will notify you 60 days prior to the change in tiers that will result in a higher Co-payment. Tier changes resulting in lower Co-payments may occur at any time and would be for your benefit. No prior notice would be given to you. When Tier status changes occur, you may pay more or less for a prescription drug depending on the Tier placement. You may access PDL and Specialty Prescription Drug Product, Tier placement and Co-payments by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

You will receive a written notice 60 days prior to an increase in your Co-payment due to the change in Tier placement to move to a higher Tier. The notice will inform you of the new Tier; and if Prior Authorization must be requested by your Network Physician and determined by UnitedHealthcare to be Medically Necessary for the drug to be covered if not previously obtained.

If A Brand-Name Drug Becomes Available as a Generic

If a Generic drug becomes available for a Brand-name drug, your Brand-name drug's Tier placement may change, and therefore your Co-payment may change. Please refer to "PRIOR AUTHORIZATION" if you are currently taking a prescription drug that requires Prior Authorization under the benefit plan.

Prior Authorization

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or unproven service.

Certain Prescription Drug Products may be subject to Prior Authorization due to the following:

- They have an approved biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

Prior Authorization and Step Therapy Exception Process

Certain Prescription Drug Products require a Prior Authorization or step therapy exception process using criteria based upon *U.S. Food and Drug (FDA)* approved indications or medical findings. When Prescription Drug Products are dispensed at a Network Pharmacy, your prescribing provider, or the pharmacist, are responsible for obtaining Prior Authorization from us. Please refer to the *Outpatient Prescription Drug Benefit Supplement* for additional information.

For a list of the Prescription Drug Products that require UnitedHealthcare's Prior Authorization, please contact UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Prescription Drug Products Covered by Your Benefit

When prescribed by your Network Physician as Medically Necessary and filled at a Network Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable:** All-in-one prefilled insulin pens insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior Authorization process.
- **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable Generic drugs may be substituted for Brand-name drugs. For Brand-name drugs that have FDA approved equivalents, a prescription may be filled with a Generic drug unless a specific Brand-name drug is Medically Necessary and Prior Authorized by UnitedHealthcare. Prior Authorization is necessary even if a licensed Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. If you choose to use a Prescription Drug Product not included on the PDL and not Prior Authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication.

If the requested drug is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your applicable Tier Co-payment

- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets and lancet devices, inhaler extender devices, urine test strips, ketone testing strips and tablets, certain immunizations, and anaphylaxis prevention kits. See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medication and equipment for the treatment of asthma in *Section 5: Your Medical Benefits.*
- **Oral Contraceptives:** All FDA-approved contraceptives, drugs, devices, and products are covered at $0 cost sharing subject to Therapeutic Equivalents that may be prescribed and may be subject to Prior Authorization. A Member may receive a 12-month supply of an FDA-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a Network provider or from a contracted pharmacy that has agreed to dispense or furnish FDA-approved contraceptives in accordance with state and federal law. Over-the-counter birth control devices require a prescription from your provider. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical *Evidence of Coverage* and to your *Outpatient Prescription Drug Rider* for more information. This includes all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved, contraceptive drugs, devices, and products available over-the-counter. Contraceptives for women from a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel. This also includes the following:
  - If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, at least one will be covered without cost-sharing or medical management restrictions. If there is no therapeutic equivalent generic substitute available in the market, the brand name contraceptive will be covered without cost-sharing or medical management restrictions.
  - All FDA-approved contraceptives will be covered without cost-sharing or medical management restrictions when deemed Medically Necessary by the prescriber.
  - Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices and products will be provided at Network pharmacies without cost sharing or medical management restrictions. A prescription will not be required to trigger coverage of these products.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most Prescription Drug Products, there are some that are not covered or limited. These Prescription Drugs Products are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form* entitled Your *Medical Benefits* for more information about medications covered by your medical benefit.

- Administered Prescription Drug Products: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form* titled Your *Medical Benefits* for more information about medications covered under your medical benefit.
- Compounded medication: Any Medicinal substance that has at least one ingredient that is federal legend or state restricted in a therapeutic amount. Compounded medications are not covered unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- Diagnostic drugs: Drugs used for diagnostic purposes are not covered. Refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form* for information about medications covered for diagnostic tests, services and treatment.

- Dietary or nutritional products and food supplements: Whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. For additional information, refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form*. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Enhancement medications when prescribed for the following non-medical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic or convenience purposes, anti-aging for cosmetic purposes, and mental performance. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer's dementia.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.
- Infertility: All forms of Prescription Drug Products when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, Prescription Drug Products for the treatment of infertility may be covered under that benefit. Please refer to *Section 5* of your medical Combined Evidence of Coverage and Disclosure Form entitled *Your Medical Benefits* for additional information.
- Injectable medications: Except as described under the section Covered Health Care Services, injectable medications including, but not limited to, infusion therapy, allergy serum, certain immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Prior Authorization requirements. For additional information, refer to *Section 5* of your medical Combined Evidence of Coverage and Disclosure Form under *Your Medical Benefits*.
- Inpatient Prescription Drug Products: Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to *Section 5* of your medical Combined Evidence of Coverage and Disclosure Form entitled *Your Medical Benefits* for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Network Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Network Physician at a Network Pharmacy and pay the applicable Co-payment on behalf of the Member.
- Investigational or Experimental drugs: Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in ***Section 5, Your Medical Benefits*** and ***Section 8: Overseeing Your Health Care Decisions*** for appeal rights.
- New Prescription Drug Products that have not been reviewed for safety, efficacy and cost effectiveness and approved by UnitedHealthcare are not covered unless Prior Authorized by UnitedHealthcare as Medically Necessary. This would include new dosage forms that we determine do not meet the definition of a Covered Health Care Service.
- Non-covered medical condition: Prescription Drug Products for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary Prescription Drug Products directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.

- Off-label drug use. Off-label drug use means that the Provider has prescribed a drug approved by the *U.S. Food and Drug Administration (FDA)* for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for off label drug use, including off label self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable *Attachments*. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a Network licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) *The American Hospital Formulary Service Drug Information*, (b) One of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapy regimen; (i) *The Elsevier Gold Standard's Clinical Pharmacology*; (ii) *The National Comprehensive Cancer Network Drug and Biologics Compendium*; (iii) *The Thompson Micromedex DRUGDEX System*, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a PDL, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the independent review system as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
- Over-the-Counter Drugs: Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form. However, this does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over-the-counter. Such determinations may be made up to six times during a calendar year. This means that if an over-the-counter drug becomes available, we may change the tier in which the drug is placed. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously limited under this provision. This exclusion does not apply to FDA-approved contraceptive drugs, devices, other products for women, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter (contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel), and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.* This also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.* This also does not apply to the following:
  - If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, at least one will be covered without cost-sharing or medical management restrictions. If there is no therapeutic equivalent generic substitute available in the market, the brand name contraceptive will be covered without cost-sharing or medical management restrictions.
  - All FDA-approved contraceptives will be covered without cost-sharing or medical management restrictions when deemed medically necessary by the prescriber.
  - Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices and products will be provided at in-network pharmacies without cost sharing or medical management restrictions. A prescription will not be required to trigger coverage of these products.
- Prescription Drug Products that are comprised of active ingredients that are available over-the-counter are not covered except when Medically Necessary. Certain prescription drug products that are Therapeutically Equivalent to over-the-counter drugs or supplement are not covered unless Medically Necessary and Prior Authorized. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over-the-counter.

- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit are not covered.
- Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government except as otherwise provided by law.
- Prescription Drug Products prescribed by a dentist or drugs when prescribed for dental treatment are not covered.
- Prescription Drug Products when prescribed solely for the purpose to shorten the duration of a common cold are not covered.
- Prescription Drug Product when packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.
- Prescription Drug Products prescribed solely to treat hair loss.
- Prior to Effective Date: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.
- Replacement of Prescription Drug Products. Lost, stolen, or destroyed Prescription Drug Products are not covered.
- Saline and irrigation solutions. Saline and irrigation solutions are not covered unless Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical *Combined Evidence of Coverage and Disclosure Form Section 5* for additional information.
- Smoking cessation products unless they are FDA-approved tobacco cessation drugs and products, both of which are provided as a preventive benefit at $0 cost sharing subject to certain exception. For information on UnitedHealthcare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in *Section 5: Your Medical Benefit* or contact Customer Service or visit our web site at **www.myuhc.com**.
- Therapeutic devices or appliances including, but not limited to, support garments and other non-medical substances, certain insulin pumps and related supplies (these services are provided as durable medical equipment). For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in *Section 5: Your Medical Benefits*.
- Therapeutically Equivalent: Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available unless Medically Necessary.
- Unit/Convenience Dosage Forms: Unit doses, pre-packaged medications, individual packets etc. are not covered unless available in that form only, prior authorized and medically necessary.
- Worker's Compensation: Prescription Drug Products for which the cost is recoverable under any *Workers' Compensation or Occupational Disease Law* or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form in Section 6: Your Payment Responsibility.*

P.O. Box 30968
Salt Lake City, UT 84130-0968

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

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Effective 2/1/2026

COUNTY OF ALAMEDA – PREMIUM PLAN

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

COUNTY OF ALAMEDA PREMIUM PLAN

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

Benefit Plan:

$15 Copayment per Visit

30 Visit 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

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

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.

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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.

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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.

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Monday through Friday, 8 a.m. – 5 p.m. PT

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.

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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.

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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.

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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

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Monday through Friday, 8 a.m. – 5 p.m. PT

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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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
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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.

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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.

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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;

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(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.

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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.

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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.

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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.

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ACNCA_Ops-05

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

ACNCA_Ops-05

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. Partic Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an employ agent of any Participating Provider. Health Plan will not be liable for any claims or demands on account of damages a out of, or in any manner connected with, any injury suffered by a Member relating to Chiropractic Services or Acupunc 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 be 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 wit terms without the necessity of either Health Plan or the Group obtaining the consent or concurrence of any Member. E electing coverage or accepting benefits under the Group Enrollment Agreement, all Members legally capable of contra and the legal representatives of all Members incapable of contracting, agree to be bound by all of the terms and condi the Group Enrollment Agreement. In the case of conflicts between the Group Enrollment Agreement and this *Combine Evidence Of Coverage and Disclosure Form*, the provisions of this *Combined Evidence Of Coverage and Disclosure F* shall be binding upon Health Plan notwithstanding any provisions of the Group Agreement that may be less favorable 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 disclos agents, affiliates, attorneys, accountants, governmental regulatory agencies, non-covered custodial parents of a cover children, or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law provisions of the Agreement, Health Plan and the Group shall keep confidential, and shall take the usual precautions t prevent the unauthorized disclosure of any and all resources required to be prepared or maintained in accordance with Agreement.

18.4 Overpayments

Member shall agree to reimburse Health Plan, on demand, any and all such amounts Health Plan pays to or on behal 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, 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 REQUES

18.6 Interpretation of Benefits

Subject to the Member grievance procedures specified in Section 16, Health Plan has the sole and exclusive discretio 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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

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.myuhc.com

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Effective: 2/01/2026

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COUNTY OF ALAMEDA – STANDARD PLAN

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits

40/500A

These services in the table below are covered as indicated when authorized through your Primary Care Physician in your Network Medical Group.

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health, and prescription drug and acupuncture benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health, and prescription drugs and acupuncture benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Individual Out-of-Pocket Limit. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	Individual: $1,500 Family: $3,000
PCP Office Visits/Telehealth Services	$40 Office Visit Co-payment
Specialist Office Visits/Telehealth Services (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$40 Office Visit Co-payment
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$500 Co-payment per admit
Emergency Services Co-payment waived if admitted	$100 Co-payment
Urgently Needed Services Urgent care services – services provided **within** the geographic area served by your medical group Urgent care services – services provided **outside** of the geographic area served by your medical group Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	$40 Co-payment $40 Co-payment

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$500 Co-payment per admit
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less)	$500 Co-payment per admit
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$500 Co-payment per admit
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$500 Co-payment per admit
Maternity Care Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	$500 Co-payment per admit
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.** Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs. (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$500 Co-payment per admit
Newborn Care The inpatient hospital benefits Co-payment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.	$500 Co-payment per admit
Physician Care (physician fees)	No charge
Reconstructive Surgery	$500 Co-payment per admit
Rehabilitation and Habilitative Care (Including physical, occupational and speech therapy)	$500 Co-payment per admit
Skilled Nursing Facility Care (Up to 100 days per benefit period)	$500 Co-payment per admit
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.** Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs.	No charge
Termination of Pregnancy (Medical/medication and surgical)	No charge

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $40 Office Visit Co-payment $40 Office Visit Co-payment
Ambulance (Only one ambulance Co-payment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Co-payment)	No charge
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply) Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	$40 Co-payment
Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days. Additional Co-payment for office visits may apply.)	No charge
Dialysis (Additional Co-payment for office visits may apply)	$40 Co-payment per treatment
Durable Medical Equipment Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children who are covered until at least the end of the month in which Member turns 19 years of age.)	No charge
Hearing Aid - Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	No charge
Hearing Aid – Bone Anchored Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered. Bone-anchored hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone-anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Hearing Exam PCP Office Visit Specialist Office Visit Co-payments for audiologist and podiatrist visits will be the same as for the PCP. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	 $40 Office Visit Co-payment $40 Office Visit Co-payment
Home Health Care Visits (Up to 100 visits per calendar year)	No charge
Home Test Kits for Sexually Transmitted Diseases	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this Schedule of Benefits
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services **If your employer group has purchased this benefit, please refer to your infertility rider for additional information**	Not covered
Infusion Therapy Infusion Therapy is a separate Co-payment in addition to a home health care of an office visit Co-payment. Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Injectable Drugs (Co-payment/Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Co-payment/Coinsurance may also apply) Outpatient Injectable Medication Self-Injectable Medication Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	$50 Co-payment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group) (Additional Co-payment for office visits may apply)	No charge

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Maternity Care, Tests and Procedures PCP Office Visit Specialist Office Visit Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	 No charge No charge
Mental Health Care Services Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing, facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental Disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, and psychiatric observation. Intensive Behavioral Therapy Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs. Schoolsite Outpatient Mental Health Care Services are covered without deductible, Co-insurance, Co-payment, or any other cost sharing requirement. **(Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)**	 $40 Office Visit Co-payment No charge No charge
Oral Surgery Services In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Outpatient Habilitative Services and Outpatient Therapy	$40 Office Visit Co-payment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$40 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
Physician Care – office visits PCP Office Visit/Telehealth Services Specialist Office Visit/Telehealth Services	 $40 Office Visit Co-payment $40 Office Visit Co-payment

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Preventive Care Services (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Health Care Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	No charge
Prosthetics and Corrective Appliances Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Co-payment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Co-payment amount if any) Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge No charge
Radiology Services Standard: (Additional Co-payment for office visits may apply) Specialized Scanning and Imaging Procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure. Applies to dollar Co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge No charge

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

Benefits Available on an Outpatient Basis (Continued)

Substance Related and Addictive Disorder Services	
Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management	No charge
All Other Outpatient Treatment includes, but are not limited to: Partial Hospitalization/ Day Treatment, High Intensity Outpatient, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment	No charge
Intensive Behavioral Therapy	No charge
Covered Health Care Services, when authorized for specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs. Schoolsite Outpatient Substance Related and Addictive Disorders Services are covered without deductible, Co-insurance, Co-payment, or any other cost sharing requirement. **Please refer to your the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	
Termination of Pregnancy (Medical/medication and surgical) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are NOT defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	No charge
Vasectomy	No charge
Virtual Care Services Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling Customer Service at the telephone number on your ID card.	$25 Co-payment
Vision Refractions	$40 Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the Allowed Amount, or the Recognized Amount as applicable, which is defined in the Evidence of Coverage.

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Network Benefits for Covered Health Care Services provided by a Network Provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at Network facilities on a non-Emergency basis at which, or as a result of which, services are received from out-of-Network Providers***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible. You shall pay no more than the same cost sharing than you would pay for the same Covered Health Care Services received from a Network Provider.

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below,*** you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Combined Evidence of Coverage and Disclosure Form.*
- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Combined Evidence of Coverage and Disclosure Form.*
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Combined Evidence of Coverage and Disclosure Form*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the *Combined Evidence of Coverage and Disclosure Form*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service A*ct with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible.

For Air Ambulance transportation provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

For Emergency ground ambulance transportation provided by an out-of-Network provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

each of the above-noted benefits is covered when authorized by your Participating Medical Group or UnitedHealthcare, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE or other services provided by Out-of-Network Providers as described above. A Utilization Review Committee may review the request for services.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT AND THE UNITEDHEALTHCARE OF CALIFORNIA COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND ADDITIONAL BENEFIT MATERIALS MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT THE UNITEDHEALTHCARE OFFICE AND YOUR EMPLOYER'S PERSONNEL OFFICE. UNITEDHEALTHCARE'S MOST RECENT AUDITED FINANCIAL INFORMATION IS ALSO AVAILABLE UPON REQUEST.

LG-NG-SOB CA No Ded (Eff. 7-1-2024)

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

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MP1,MX1,MY1
Effective: 2/1/2026

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COUNTY OF ALAMEDA – STANDARD PLAN

UnitedHealthcare®

SignatureValue™ HMO Offered by UnitedHealthcare of California

Pharmacy Schedule of Benefits

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's Tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at **www.myuhc.com** or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization participation or activation requirements associated with such programs by contacting us at **www.myuhc.com** or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications, including FDA-approved contraceptive drugs, devices and products available when prescribed by a Network provider. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at **www.myuhc.com** or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower Tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Variable Co-payment Program**: Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact **www.myuhc.com** or the telephone number on your ID card for an available list of Prescription Drug Products and the applicable Co-payment and/or Co-insurance. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at **www.myuhc.com** or the telephone number on your ID card. **NOTE:** The Tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's Tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its Tier placement. Please contact us at **www.myuhc.com** or the telephone number on your ID card for the most up-to-date Tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications. A 12-month supply of $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives. This includes all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved, contraceptive drugs, devices, and products available over-the-counter. Contraceptives for women from a Network pharmacy include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel. This also includes the following: • If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, at least one will be covered without cost-sharing or medical management restrictions. If there is no therapeutic equivalent generic substitute available in the market, the brand name contraceptive will be covered without cost-sharing or medical management restrictions. • All FDA-approved contraceptives will be covered without cost-sharing or medical management restrictions when deemed Medically Necessary by the prescriber.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's Tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, or Tier 2, or Tier 3. Please contact us at **www.myuhc.com** or the telephone number on your ID card to find out Tier status. For a Tier 1 Prescription Drug Product: $25 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 3 Prescription Drug Product: $50 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
• Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices and products will be provided at Network pharmacies without cost sharing or medical management restrictions. A prescription will not be required to trigger coverage of these products. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. All cost sharing applies to the Out-of-Pocket Limit.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drug Products. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 31-day supply with three refills.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's Tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, or Tier 2, or Tier 3. Please contact us at **www.myuhc.com** or the telephone number on your ID card to find out Tier status. For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $50 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 2 Prescription Drug Product: $70 per Prescription Order or Refill

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
	Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. For a Tier 3 Prescription Drug Product: $100 per Prescription Order or Refill Co-payment maximum of $250 ("Cap") for up to a 31-day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form, Section 10: Definitions, for the definition of a High Deductible Health Plan. All cost sharing applies to the Out-of-Pocket Limit.

This *Schedule of Benefits* provides specific details about your Prescription Drug Product benefit, as well as the exclusions and limitations. Together this document and the *Supplement to the Combined Evidence of Coverage and Disclosure Form* as well as the medical *Combined Evidence of Coverage and Disclosure Form* determine the exact terms and conditions of your Prescription Drug Product coverage.

What do I Pay When I fill a Prescription?

The amount you pay for any of the following under this Pharmacy *Schedule of Benefits* will not be included in calculating any Out-of-Pocket Limit stated in your medical Schedule of Benefits:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates will not be available to you.

For Prescription Drug Products at a Network Retail pharmacy, you will pay the lower of the applicable Co-payment for a Prescription Unit, or the Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from mail order, you are responsible for paying the lower of either the applicable Co-payment or a Network Pharmacy's retail price for the Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Network Pharmacy. Your Co-payments are as shown in the grid above.

NOTE: The Tier status of a prescription drug can change periodically. Tier status changes resulting in higher Co-payments occur four times per calendar year or Contract Year. We will notify you 60 days prior to the change in tiers that will result in a higher Co-payment. Tier changes resulting in lower Co-payments may occur at any time and would be for your benefit. No prior notice would be given to you. When Tier status changes occur, you may pay more or less for a prescription drug depending on the Tier placement. You may access PDL and Specialty Prescription Drug Product, Tier placement and Co-payments by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

You will receive a written notice 60 days prior to an increase in your Co-payment due to the change in Tier placement to move to a higher Tier. The notice will inform you of the new Tier; and if Prior Authorization must be requested by your Network Physician and determined by UnitedHealthcare to be Medically Necessary for the drug to be covered if not previously obtained.

If A Brand-Name Drug Becomes Available as a Generic

If a Generic drug becomes available for a Brand-name drug, your Brand-name drug's Tier placement may change, and therefore your Co-payment may change. Please refer to "PRIOR AUTHORIZATION" if you are currently taking a prescription drug that requires Prior Authorization under the benefit plan.

Prior Authorization

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or unproven service.

Certain Prescription Drug Products may be subject to Prior Authorization due to the following:

- They have an approved biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

Prior Authorization and Step Therapy Exception Process

Certain Prescription Drug Products require a Prior Authorization or step therapy exception process using criteria based upon *U.S. Food and Drug (FDA)* approved indications or medical findings. When Prescription Drug Products are dispensed at a Network Pharmacy, your prescribing provider, or the pharmacist, are responsible for obtaining Prior Authorization from us. Please refer to the *Outpatient Prescription Drug Benefit Supplement* for additional information.

For a list of the Prescription Drug Products that require UnitedHealthcare's Prior Authorization, please contact UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Prescription Drug Products Covered by Your Benefit

When prescribed by your Network Physician as Medically Necessary and filled at a Network Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable:** All-in-one prefilled insulin pens insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior Authorization process.
- **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable Generic drugs may be substituted for Brand-name drugs. For Brand-name drugs that have FDA approved equivalents, a prescription may be filled with a Generic drug unless a specific Brand-name drug is Medically Necessary and Prior Authorized by UnitedHealthcare. Prior Authorization is necessary even if a licensed Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. If you choose to use a Prescription Drug Product not included on the PDL and not Prior Authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication.

If the requested drug is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your applicable Tier Co-payment

- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets and lancet devices, inhaler extender devices, urine test strips, ketone testing strips and tablets, certain immunizations, and anaphylaxis prevention kits. See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medication and equipment for the treatment of asthma in *Section 5: Your Medical Benefits.*
- **Oral Contraceptives:** All FDA-approved contraceptives, drugs, devices, and products are covered at $0 cost sharing subject to Therapeutic Equivalents that may be prescribed and may be subject to Prior Authorization. A Member may receive a 12-month supply of an FDA-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a Network provider or from a contracted pharmacy that has agreed to dispense or furnish FDA-approved contraceptives in accordance with state and federal law. Over-the-counter birth control devices require a prescription from your provider. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical *Evidence of Coverage* and to your *Outpatient Prescription Drug Rider* for more information. This includes all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved, contraceptive drugs, devices, and products available over-the-counter. Contraceptives for women from a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel. This also includes the following:
  - If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, at least one will be covered without cost-sharing or medical management restrictions. If there is no therapeutic equivalent generic substitute available in the market, the brand name contraceptive will be covered without cost-sharing or medical management restrictions.
  - All FDA-approved contraceptives will be covered without cost-sharing or medical management restrictions when deemed Medically Necessary by the prescriber.
  - Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices and products will be provided at Network pharmacies without cost sharing or medical management restrictions. A prescription will not be required to trigger coverage of these products.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most Prescription Drug Products, there are some that are not covered or limited. These Prescription Drugs Products are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form* entitled Your *Medical Benefits* for more information about medications covered by your medical benefit.

- Administered Prescription Drug Products: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form* titled Your *Medical Benefits* for more information about medications covered under your medical benefit.
- Compounded medication: Any Medicinal substance that has at least one ingredient that is federal legend or state restricted in a therapeutic amount. Compounded medications are not covered unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- Diagnostic drugs: Drugs used for diagnostic purposes are not covered. Refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form* for information about medications covered for diagnostic tests, services and treatment.

- Dietary or nutritional products and food supplements: Whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. For additional information, refer to *Section 5* of your medical *Combined Evidence of Coverage and Disclosure Form*. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Enhancement medications when prescribed for the following non-medical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic or convenience purposes, anti-aging for cosmetic purposes, and mental performance. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer's dementia.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.
- Infertility: All forms of Prescription Drug Products when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, Prescription Drug Products for the treatment of infertility may be covered under that benefit. Please refer to *Section 5* of your medical Combined Evidence of Coverage and Disclosure Form entitled *Your Medical Benefits* for additional information.
- Injectable medications: Except as described under the section Covered Health Care Services, injectable medications including, but not limited to, infusion therapy, allergy serum, certain immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Prior Authorization requirements. For additional information, refer to *Section 5* of your medical Combined Evidence of Coverage and Disclosure Form under *Your Medical Benefits*.
- Inpatient Prescription Drug Products: Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to *Section 5* of your medical Combined Evidence of Coverage and Disclosure Form entitled *Your Medical Benefits* for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Network Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Network Physician at a Network Pharmacy and pay the applicable Co-payment on behalf of the Member.
- Investigational or Experimental drugs: Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in ***Section 5, Your Medical Benefits*** and ***Section 8: Overseeing Your Health Care Decisions*** for appeal rights.
- New Prescription Drug Products that have not been reviewed for safety, efficacy and cost effectiveness and approved by UnitedHealthcare are not covered unless Prior Authorized by UnitedHealthcare as Medically Necessary. This would include new dosage forms that we determine do not meet the definition of a Covered Health Care Service.
- Non-covered medical condition: Prescription Drug Products for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary Prescription Drug Products directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.

- Off-label drug use. Off-label drug use means that the Provider has prescribed a drug approved by the *U.S. Food and Drug Administration (FDA)* for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for off label drug use, including off label self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable *Attachments*. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a Network licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) *The American Hospital Formulary Service Drug Information*, (b) One of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapy regimen; (i) *The Elsevier Gold Standard's Clinical Pharmacology*; (ii) *The National Comprehensive Cancer Network Drug and Biologics Compendium*; (iii) *The Thompson Micromedex DRUGDEX System*, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a PDL, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the independent review system as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
- Over-the-Counter Drugs: Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form. However, this does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over-the-counter. Such determinations may be made up to six times during a calendar year. This means that if an over-the-counter drug becomes available, we may change the tier in which the drug is placed. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously limited under this provision. This exclusion does not apply to FDA-approved contraceptive drugs, devices, other products for women, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter (contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel), and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.* This also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.* This also does not apply to the following:
  - If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, at least one will be covered without cost-sharing or medical management restrictions. If there is no therapeutic equivalent generic substitute available in the market, the brand name contraceptive will be covered without cost-sharing or medical management restrictions.
  - All FDA-approved contraceptives will be covered without cost-sharing or medical management restrictions when deemed medically necessary by the prescriber.
  - Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices and products will be provided at in-network pharmacies without cost sharing or medical management restrictions. A prescription will not be required to trigger coverage of these products.
- Prescription Drug Products that are comprised of active ingredients that are available over-the-counter are not covered except when Medically Necessary. Certain prescription drug products that are Therapeutically Equivalent to over-the-counter drugs or supplement are not covered unless Medically Necessary and Prior Authorized. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over-the-counter.

- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit are not covered.
- Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government except as otherwise provided by law.
- Prescription Drug Products prescribed by a dentist or drugs when prescribed for dental treatment are not covered.
- Prescription Drug Products when prescribed solely for the purpose to shorten the duration of a common cold are not covered.
- Prescription Drug Product when packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.
- Prescription Drug Products prescribed solely to treat hair loss.
- Prior to Effective Date: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.
- Replacement of Prescription Drug Products. Lost, stolen, or destroyed Prescription Drug Products are not covered.

- Saline and irrigation solutions. Saline and irrigation solutions are not covered unless Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical *Combined Evidence of Coverage and Disclosure Form Section 5* for additional information.
- Smoking cessation products unless they are FDA-approved tobacco cessation drugs and products, both of which are provided as a preventive benefit at $0 cost sharing subject to certain exception. For information on UnitedHealthcare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in *Section 5: Your Medical Benefit* or contact Customer Service or visit our web site at **www.myuhc.com**.
- Therapeutic devices or appliances including, but not limited to, support garments and other non-medical substances, certain insulin pumps and related supplies (these services are provided as durable medical equipment). For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in *Section 5: Your Medical Benefits*.
- Therapeutically Equivalent: Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available unless Medically Necessary.
- Unit/Convenience Dosage Forms: Unit doses, pre-packaged medications, individual packets etc. are not covered unless available in that form only, prior authorized and medically necessary.
- Worker's Compensation: Prescription Drug Products for which the cost is recoverable under any *Workers' Compensation or Occupational Disease Law* or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form in Section 6: Your Payment Responsibility.*

P.O. Box 30968
Salt Lake City, UT 84130-0968

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

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Effective 2/1/2026

COUNTY OF ALAMEDA – STANDARD PLAN

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

COUNTY OF ALAMEDA STANDARD PLAN

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

Benefit Plan:

$20 Copayment per Visit

30 Visit 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

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

ACNCA_Ops-05

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

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.

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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.

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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.

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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.

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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.

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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.

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Monday through Friday, 8 a.m. – 5 p.m. PT

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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

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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.

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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.

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ACNCA_Ops-05

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.

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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;

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ACNCA_Ops-05

(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.

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ACNCA_Ops-05

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.

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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.

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ACNCA_Ops-05

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

ACNCA_Ops-05

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.

Questions? Call OptumHealth Customer Service: 1-800-428-6337 (HMO)
Monday through Friday, 8 a.m. – 5 p.m. PT

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.myuhc.com

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Effective: 2/1/2026

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UnitedHealthcare | California | Select Plus | DKS3 | G95S

Select Plus plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Select Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☑
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free.Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Select Plus works

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$500	$1,500
Family	$1,000	$3,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$4,500	$13,500
Family	$9,000	$27,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services	
Copays ($) and Coinsurance (%) for Covered Health Care Services	**Network**	**Out-of-Network**
Preventive Care Services		
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.*	No copay	Not covered
Office Services - Sickness & Injury		
Primary Care Physician *Telehealth is covered at the same cost share as in the office.*	$20 copay	50%*
Specialist *Telehealth is covered at the same cost share as in the office.*	$40 copay	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Urgent Care Center Services	$50 copay	50%*
Virtual Care Services *Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to 24/7 Virtual Visits and prescription services may not be available in all states or for all groups.*	No copay	Not covered
Vision Exams *Limited to 1 exam every 24 months.* *Find a listing of UnitedHealthcare Vision Network Providers at myuhcvision.com.*	$20 copay	Not covered
Emergency Care		
Ambulance Services - Emergency Ambulance		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	50%*
Dental Services - Accident Only	20%*	20%*
Emergency Health Care Services - Outpatient	20%*	20%*
Inpatient Care		
Congenital Heart Disease (CHD) Surgeries[1]	20%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.	
Hospital - Inpatient Stay[1]	20%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 100 days per year in a Skilled Nursing Facility.*	20%*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Outpatient Care		
Habilitative Services - Outpatient *Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* *Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatment.* *Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including Autism Spectrum Disorders.*	$20 copay	50%*
Home Health Care[1] *Limited to 100 visits per year.* *Out of Network: Limited to $150 per visit for Allowed Amounts.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing		
For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office	No copay	Not covered
For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center	20%	Not covered
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		
For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office	20%	50%*
For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center	20%	50%*
Major Diagnostic and Imaging - Outpatient[1]		
For services provided at a freestanding diagnostic center or in a physician's office	20%*	50%*
For services provided at an outpatient hospital-based diagnostic center *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	20%*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Physician Fees for Surgical and Medical Services	20%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 24 visits of manipulative treatments per year.* *Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatment.* *Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including Autism Spectrum Disorders.*	$20 copay	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
For services provided at a freestanding center or in a physician's office	20%*	50%*
For services provided at an outpatient hospital-based center *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	20%*	50%*
Surgery - Outpatient[1]		
For services provided at an ambulatory surgical center or in a physician's office	20%*	50%*
For services provided at an outpatient hospital-based surgical center *Out of Network: Limited to $760 per date of service for Allowed Amount of Facility Fees.* *There is no cost for network vasectomy services or procedures.*	20%*	50%*
Therapeutic Treatments - Outpatient[1] *Out-of-Network Benefits are not available for dialysis services.* *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	20%*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Supplies and Services		
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1] *For self-management and training, cost sharing will not exceed the costs for Physician office visits.*	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment (DME), Orthotics and Supplies	20%*	Not covered
Enteral Nutrition	20%*	50%*
Hearing Aids *Limited to $2,500 per year.* *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	20%*	50%*
Ostomy Supplies	20%*	Not covered
Pharmaceutical Products - Outpatient *This includes medications given on an outpatient basis in a Hospital, Alternate Facility, doctor's office, or in a covered person's home.*	20%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	20%*	50%*
Urinary Catheters	20%*	Not covered

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Pregnancy		
Pregnancy - Maternity Services[1] *All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care act, will be provided without cost share. Please refer to Preventive Care Services.* *We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.*	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	20%*	50%*
Intensive Behavioral Therapy (e.g. ABA)[1]	10%	50%*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment[1]	20%*	50%*
Outpatient Office Visits *There is no cost for school site outpatient Mental Health Care and Substance-Related and Addictive Disorders Services.*	$20 copay	50%*
Other Services		
Abortion and Abortion Related Services	No copay	No copay
Cellular and Gene Therapy *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia Services[1] *Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled, regardless of age; a person whose health is compromised and for whom general anesthesia is required, regardless of age.*	20%*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Emergency Medical Services Provided by a Community Paramedicine Program, a Triage to Alternate Destination Program, and a Mobile Integrated Health Program	The amount you pay is based on where the covered health care service is provided.	
Emergency Room Medical Care and Follow-up Health Care Treatment for Rape and Sexual Assault		
All visits for the first nine months after treatment is initiated	No copay	50%*
Subsequent visits after nine months treatment is initiated	20%*	50%*
There is no cost for emergency room medical care and follow-up health care treatment for a Covered Person who is treated following a rape or sexual assault for the first nine months after treatment is initiated.		
Fertility Preservation for Iatrogenic Infertility[1]	20%*	50%*
Limited to 1 cycle of fertility preservation for Iatrogenic Infertility per lifetime.		
Gender Dysphoria	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Limits for voice modification therapy and/or voice lessons will be the same as, and combined with, outpatient speech therapy limits as described under Habilitative Services and Rehabilitation Services Outpatient Therapy and Manipulative Treatment.		
Home Test Kits for Sexually Transmitted Diseases	No copay	50%*
Hospice Care[1]	20%*	50%*
Human Milk	20%*	50%*
Infertility Services[1]	20%*	50%*
Mastectomy Services[1]	The amount you pay is based on where the covered health care service is provided.	
Obesity - Weight Loss Surgery[1]	The amount you pay is based on where the covered health care service is provided.	Not covered
Limited to 1 procedure per lifetime.		
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.		
Off-Label Drug Use and Experimental or Investigational Services	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Network	Out-of-Network
Osteoporosis Services	The amount you pay is based on where the covered health care service is provided.	
Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)	The amount you pay is based on where the covered health care service is provided.	
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.*	20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Telehealth Services	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services[1]	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage w/ SMCS Drugs
	In Network and Out of Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

	Up to a 31-day supply		Up to a 90-day supply
Prescription Drug Product Tier Level	**In-Network Retail Pharmacy**	**Out-of-Network Retail Pharmacy**	**In-Network Mail Order Pharmacy****
Tier 1 $	$10	$10	$25
Tier 2 $$	$35	$35	$87.50
Tier 3 $$$	$85	$85	$212.50
Specialty Prescription Drug Product Tier Level	**In-Network Specialty Pharmacy**	**Out-of-Network Specialty Pharmacy**	**Specialty Mail Order**
Tier 1 $	$10	$10	Not applicable
Tier 2 $$	$150	$150	Not applicable
Tier 3 $$$	$250	$250	Not applicable

* After the Annual Pharmacy Deductible has been met.
** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.
Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.
If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.
For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.
Specialty medication cost share (SMCS) encourages you to talk to your doctor about lower cost medication options. You may pay more if you do not pick a lower cost option.

Here's an example of how the plan's costs come into play

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance.***

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

*Your coinsurance may vary by service. This example is for illustrative purposes only.

Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools - the **UnitedHealthcare® app** and **myuhc.com®** - these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

Get connected

Scan this code to download the UnitedHealthcare app or visit myuhc.com

Other important information about your benefits

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at an In-Network Retail Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The In- Network Retail Pharmacy Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from an In-Network Mail Order Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Retail Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or pharmaceutical product(s) for which Benefits are provided as described under the Certificate first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Evidence of Coverage.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss. This exclusion does not apply to outpatient Prescription Drug Products prescribed and prior authorized for the Medically Necessary treatment of morbid obesity.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury except as required for PKU as described under Enteral Nutrition in Section 1 of the Evidence of Coverage.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter. This exclusion does not apply to FDA-approved contraceptive drugs, devices, other products for women, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter, and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1: Covered Health Care Services. This also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1: Covered Health Care Services.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Evidence of Coverage. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not apply to Prescription Drug Products described under Off-Label Drug Use and Experimental or Investigational Services in Section 1 of the Evidence of Coverage.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service, unless medically necessary.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

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

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

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

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

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

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

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

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

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

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

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

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

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

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

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

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

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

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વગર મૂલ્યે પરાપત્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલા સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

Underwritten by UnitedHealthcare Benefits Plan of CA.

Administrative services provided by United HealthCare Services, Inc. and their affiliates.

COUNTY OF ALAMEDA – PREMIUM

UnitedHealthcare®

Infertility Basic Diagnosis and Treatment Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form

This brochure contains important information for our Members about the UnitedHealthcare Infertility Basic Diagnosis and Treatment supplemental benefit. As a Member you shall be entitled to receive basic diagnostic services and treatment for infertility as described in this brochure. You will find important definitions in the back of this document regarding your infertility supplemental benefit.

Benefits

UnitedHealthcare's Basic Infertility Services must be Medically Necessary and consistent with accepted standards of care for the diagnosis and treatment of infertility. Services must be authorized and directed by the Participating Medical Group or the UnitedHealthcare SignatureValue® Advantage Participating Medical Group (for Advantage participants) and benefits are subject to the Exclusions and Limitations stated below:

Diagnosis of Infertility

a. Complete medical history.

b. General medical examinations. Examples include but are not limited to:
   - Pelvic exam;
   - Routine laboratory investigation for hormonal disturbances (e.g., FSH, LH, prolactin);
   - Cultures for infectious agents;
   - Serum progesterone determination;
   - Laparoscopy;
   - Hysterosalpingogram.
   - Semen analysis up to three times following five days of abstinence;
   - Huhner's Test or Post-Coital Examinations;
   - Laboratory studies (e.g., FSH, LH, prolactin, serum testosterone);
   - Testicular biopsy when Member has demonstrated azoospermia;
   - Scrotal ultrasound, when appropriate for azoospermia;
   - Electrical Assistance for Recovery of Sperm (EARS), when medically indicated, as when the Member is a paraplegic or quadriplegic, as approved by UnitedHealthcare's Medical Director or designee;
   - HIV, Hepatitis B surface antibody, Hepatitis C antibody, HTLV-1 and syphilis testing of partner prior to artificial insemination.

Treatment of Infertility

a. Insemination Procedures are limited to six procedures per lifetime, unless the Member conceives, in which case the benefit renews.

b. Clomid used during the covered periods of infertility is covered as part of this Supplemental Benefit and is not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage.

c. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes.

d. Injectable medications and syringes for the treatment of infertility are covered as part of this Supplemental Infertility Benefit and are not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage. Examples include:
   - Pergonal;
   - Profasi;
   - Metrodin;
   - Urofollitropin;

Coverage for other injectable drugs not listed above will be reviewed based on Medical Necessity for the specific Member, and Food and Drug Administration (FDA) recommendations, including off-label use for the drug requested.

Coverage

All benefits, including physician services, procedures, diagnostic services or medications, are covered at 50 percent of cost Copayment (based upon UnitedHealthcare's contractual rate for the services provided with the infertility provider(s)).

Exclusions

- Services not authorized and directed by the Participating Medical Group or the Advantage Participating Medical Group (for Advantage participants).
- Medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, anorgasmy or hyporgasmy.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any

supplies, medications, services and/or procedures used for an excluded benefit, e.g., , ZIFT or IVF.
- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.
- Experimental and/or Investigational diagnostic studies or procedures, as determined by UnitedHealthcare's Medical Director or Designee.
- Advanced infertility procedures, as well as In Vitro Fertilization (IVF), and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, and ZIFT.
- Infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when infertility exists; e.g., use of another relative's sperm.
- Artificial insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
   a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
   b. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;
2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the UnitedHealthcare Medical Director or designee determines that:
   a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
   b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
   c. The Member has received the lifetime benefit maximum of six artificial insemination procedures, cumulatively, under one or more UnitedHealthcare Health Plans, has occurred.
3. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes
4. Advanced Reproductive Therapy, as excluded under this Basic Infertility Services benefit are:
   a. In Vitro Fertilization (IVF). A highly sophisticated infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. If fertilization and cell division occur, the resulting embryo(s) are transferred to the uterine cavity where implantation and pregnancy may occur.
   b. Zygote Intrafallopian Transfer (ZIFT). An infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. The fertilized oocytes, or zygotes, are transferred to the fallopian tube before cell division occurs. The intent of this procedure is to have the zygote travel to the uterus via the fallopian tube.
5. Lifetime benefit maximum is individually cumulative for the Member over one or more UnitedHealthcare plans. Any Member that terminates from a UnitedHealthcare Health Plan with a lifetime benefit maximum, and subsequently re-enrolls in another UnitedHealthcare Plan with a lifetime benefit maximum, will carry over any previous benefit utilization calculated by his or her previous UnitedHealthcare benefit coverage into the new UnitedHealthcare Benefit plan. In the event the Member has exhausted the lifetime benefit maximum on the previous UnitedHealthcare Health Plan, the Member is no longer eligible for any further benefits.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service
800-624-8822
711 (TTY)
welcometouhc.com/alameda

CALIFORNIA

UnitedHealthcare®

Mental Health and Substance-Related and Addictive Disorder Services, Provided by U.S. Behavioral Health Plan, California

Schedule of Benefits

Pre-Authorization is required for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through U.S Behavioral Health Plan, California (USBHPC) for Inpatient services, Residential Treatment services, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment; and Psychological Testing, except in the event of an Emergency. USBHPC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient and Residential Treatment Medically Necessary Mental Health services provided at an Inpatient Treatment Center	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment (includes individual/ group counseling/ monitoring drug therapy) Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing , applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Substance-Related and Addictive Disorder Services

Inpatient and Residential Treatment Medically Necessary treatment of Substance-Related and Addictive Disorders, Including Medical Detoxification, provided at a Participating Facility	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]

Substance-Related and Addictive Disorder Services (Continued)

Outpatient Treatment Outpatient Treatment for Substance-Related and Addictive Disorder Services includes outpatient evaluation and treatment for chemical dependency: • individual and group Substance-Related and Addictive Disorder counseling; • medical detoxification • methadone maintenance treatment; and • outpatient treatment extended beyond 45 minutes.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child[3]

Inpatient and Residential Treatment Unlimited days	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing, applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

[1] Each Hospital Admission may require an additional Copayment. Please refer to your UnitedHealthcare of California Medical Plan *Schedule of Benefits.*

[2] Emergency and Urgently Needed Services are Medically Necessary behavioral health services required outside the Service Area to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient servility, including severe pain, and may result in immediate harm to self or others; placing one's health in serious jeopardy; serious impairment of one's functioning; or serious dysfunction of any bodily organ or part, therefore such treatment cannot be delayed until the Member returns to the Service Area. Please refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for detailed information on this benefit.

[3] Severe Mental Illness (SMI) diagnoses include: Anorexia Nervosa; Bipolar Disorder; Bulimia Nervosa; Major Depressive Disorders; Obsessive-Compulsive Disorder; Panic Disorder; Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism; Schizoaffective Disorder; Schizophrenia. Serious Emotional Disturbance (SED) of a Child Under Age 18 includes a condition identified as a Mental Disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance-related and addictive disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

- As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either:
  (i) the child is at risk of removal from home or has already been removed from the home; or
  (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays psychotic features or risk of suicide or violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

P.O. Box 2839
San Francisco, CA 94126

Customer Service:
800-999-9585
711 (TTY)
www.liveandworkwell.com

DELTA DENTAL®

Your Smile, Your Choice

Delta Dental PPO™ & DeltaCare® USA

You can choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks and affordable preventive care. Your options are:

Delta Dental PPO[1]

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.[2] Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles.[3]

Turn the page for more details to help you choose the best plan for your needs.

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

[3] Refer to your plan booklet for more information about covered services, deductibles and maximums.

deltadentalins.com/enrollees

Compare plan features

	Delta Dental PPO	DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits.[2]
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at low or no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has low or no copayments.
Are there deductibles and maximums?	Yes, most plans have an annual deductible and maximum.	No, there are no annual deductibles or maximums.[4]
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date.[5] Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral.[6]
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting us.	You can change your selected or assigned primary care dentist online or by telephone.[7]
Do I need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non–Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan.[8]

[4] In AK, CT, ND and SD, you have an out-of-network calendar year maximum of $500 when you visit an out-of-network dentist.

[5] Except in Texas; please refer to your plan booklet for details.

[6] Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by an in-network specialist. Refer to your plan booklet for details.

[7] In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

[8] You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York, Inc.; DE – Delta Dental of Delaware, Inc.; WV – Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

EF3_PPO_DCU #133904.01 (rev. 03/22)

DELTA DENTAL

Maximize Your Savings

Visit a PPO dentist

Choose an in-network dentist to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.

- You'll save the most by visiting a **Delta Dental PPO™** dentist.
- Your next best bet, **Delta Dental Premier®**, is the largest dental network nationwide.[1]

Find a network dentist at **deltadentalins.com.**

Both networks offer:

- Reduced out-of-pocket costs
- No balance billing
- No claims to fill out
- Large selection of dentists
- Quality assurance

You pay less for a crown with PPO[2]

	Delta Dental PPO dentist	Delta Dental Premier® dentist	Non-Delta Dental dentist
Dentist charges	$1,428	$1,428	$1,428
Dentist accepts as full payment	$729	$1,081	$1,428
Crown Benefit	80% of PPO fee	80% of Premier fee	80% of Plan Allowance
Your plan pays	$583	$865	$728
You pay	**$146**	**$216**	**$700**

You save the most with Delta Dental PPO

[1] Delta Dental Premier is the largest dentist network nationwide based on total unique dentists, as of September 2021, according to Zelis Network360.

[2] This is for illustrative purposes only. Assume no maximum or deductibles apply.

Delta Dental PPO and Delta Dental Premier® are offered by County of Alameda and administered by Delta Dental of California.

deltadentalins.com/enrollees

DELTA DENTAL®

Keep smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

HL_PPO #135419F (rev. 1/23)

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: County Of Alameda
(Plan 1550)
Group No: 02155

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$45 per person each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,550 per person each plan year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics 12 Months	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	100%
Basic Services Fillings, sealants and posterior composites	85%	80%
Endodontics (root canals) Covered Under Basic Services	85%	80%
Periodontics (gum treatment) Covered Under Basic Services	85%	80%
Oral Surgery Covered Under Basic Services	85%	80%
Major Services Crowns, onlays and cast restorations	80%	80%
Prosthodontics Bridges, dentures and implants	80%	80%
Temporomandibular Joint (TMJ) Benefits	60%	60%
Temporomandibular Joint (TMJ) Maximums	$1,000 Lifetime	$1,000 Lifetime
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com/coa

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 8/21/2025

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: County Of Alameda
(Plan 1650)
Group No: 02155 **Effective Date:** 2/1/2026

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$45 per person each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,650 per person each plan year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics 12 Months	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	100%
Basic Services Fillings, sealants and posterior composites	85%	80%
Endodontics (root canals) Covered Under Basic Services	85%	80%
Periodontics (gum treatment) Covered Under Basic Services	85%	80%
Oral Surgery Covered Under Basic Services	85%	80%
Major Services Crowns, onlays and cast restorations	80%	80%
Prosthodontics Bridges, dentures and implants	80%	80%
Temporomandibular Joint (TMJ) Benefits	60%	60%
Temporomandibular Joint (TMJ) Maximums	$1,000 Lifetime	$1,000 Lifetime
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com/coa

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 8/22/2025

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: County Of Alameda
(Plan 1750)
Group No: 02155 **Effective Date:** 2/1/2026

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$45 per person each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,750 per person each plan year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics 12 Months	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	100%
Basic Services Fillings, sealants and posterior composites	85%	80%
Endodontics (root canals) Covered Under Basic Services	85%	80%
Periodontics (gum treatment) Covered Under Basic Services	85%	80%
Oral Surgery Covered Under Basic Services	85%	80%
Major Services Crowns, onlays and cast restorations	80%	80%
Prosthodontics Bridge, dentures and implants	80%	80%
Temporomandibular Joint (TMJ) Benefits	60%	60%
Temporomandibular Joint (TMJ) Maximums	$1,000 Lifetime	$1,000 Lifetime
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com/coa

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 8/22/2025

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: County Of Alameda
(Plan 1900)
Group No: 02155 **Effective Date:** 2/1/2026

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$45 per person each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,900 per person each plan year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics 12 Months	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	100%
Basic Services Fillings, sealants and posterior composites	85%	80%
Endodontics (root canals) Covered Under Basic Services	85%	80%
Periodontics (gum treatment) Covered Under Basic Services	85%	80%
Oral Surgery Covered Under Basic Services	85%	80%
Major Services Crowns, onlays and cast restorations	80%	80%
Prosthodontics Bridges, dentures and implants	80%	80%
Temporomandibular Joint (TMJ) Benefits	85%	80%
Temporomandibular Joint (TMJ) Maximums	$1,000 Lifetime	$1,000 Lifetime
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com/coa

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 8/22/2025

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: County Of Alameda
(Supplemental Plan – 600)
Group No: 02155

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	None			
Maximums D & P counts toward maximum?	$600 per person each plan year Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	25%	25%
Basic Services Fillings and posterior composites	25%	25%
Endodontics (root canals) Covered Under Basic Services	25%	25%
Periodontics (gum treatment) Covered Under Basic Services	25%	25%
Oral Surgery Covered Under Basic Services	25%	25%
Major Services Crowns, onlays and cast restorations	25%	25%
Prosthodontics Bridges, dentures and implants	25%	25%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com/coa

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 8/21/2025

DELTA DENTAL®

Benefit highlights

DeltaCare® USA

DeltaCare USA[1] offers you straightforward and affordable care from a trusted in-network dentist that you choose.[2] You know everything your plan covers and what each procedure costs. No surprises.

Comprehensive coverage

- Coverage for 350+ procedures
- Regular preventive care at low or no cost to help stop serious problems from developing
- Specialist services for oral surgery, endodontics, orthodontics, periodontics and pediatric dentistry

Budget-friendly

- No deductibles or maximums[3] for covered services
- Transparent out-of-pocket costs listed in your plan booklet or online account[4]
- All-inclusive copayments (no material or lab fees)
- Cleanings and exams covered at low or no cost

Large network of quality dentists

Delta Dental is a leading national carrier that offers a large network of high-quality and rigorously vetted dentists to choose from.

Convenient services

We make it easy for you — your DeltaCare USA network dentist will take care of all the paperwork, and no ID card is required to receive treatment.[5]

LEGAL NOTICES: Access federal and state legal notices related to your plan: **deltadentalins.com/about/legal/index-enrollee.html**

[1] DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Delta Dental is a registered trademark of Delta Dental Plans Association.

West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.

[2] Verify your selected DeltaCare USA general dentist before each appointment.

[3] Plans with an Accidental Injury Rider have a $1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

[4] State-specific exceptions may apply.

[5] Delta Dental Insurance Company provides benefits as a Prepaid Limited Health Services Organization as described in Chapter 636 of the Florida Statutes.

deltadentalins.com/members

SCCASTD **Administered by Delta Dental Insurance Company** HL_DCU_CA41R_V25_W_EN_03.25.25_LTR

What you need to know in advance, or about your DeltaCare® USA plan

How DeltaCare USA works

We make it easy for you — your DeltaCare USA network dentist will take care of all the paperwork, and no plan ID card is required to receive treatment.

- **You must visit** a DeltaCare USA general dentist to use your plan.[1]
  - Dependent children under the age of 14 may obtain covered care from an in-network pediatric dentist without referral from a general dentist. Your general dentist will coordinate and refer you to specialists for care, if needed.
- **You may select** an in-network general dentist, or a general dentist can be assigned at first visit if you haven't selected a dentist yet.[2]
- **You can select** or change dentists anytime online or by phone.
- **Pay predefined**, all-inclusive copayments — with no hidden fees (no material or lab fees) at the time of service. Consult your plan booklet for coverage.
- **No deductibles, maximums or waiting periods** for covered services. No claims to submit — no hassle!
- **Transparent out-of-pocket costs** shown in your plan booklet or online account

What your plan covers

You're covered for hundreds of procedures with no annual limit on the amount your plan pays.

- Comprehensive coverage for 350+ procedures that prioritizes preventive care
- Cleanings and exams covered with low or no copayments
- Orthodontics coverage for adults and children, including clear aligners
- Extensive care including crowns, dentures, root canals, oral surgery and more

Getting started

To enroll in a DeltaCare USA plan, simply complete the enrollment process as directed by your benefits administrator. Select a new DeltaCare USA dentist or check to see if your preferred general dentist is in-network.

Once we process your enrollment, we'll mail you welcome materials that will include:

- **The name, address and phone number of your selected general dentist or instructions on how to select one.** Simply call the dental facility to make an appointment. Important note: In order to receive benefits under your plan, you must visit your general dentist facility. You can visit any DeltaCare USA general dentist at your selected dental facility as long as they are in the DeltaCare USA network.
- **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
- **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.

Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your general dentist and more.

General plan information

You and your eligible dependents have emergency dental service coverage for out-of-area emergencies.[3] Your out-of-area emergency benefit (typically limited to $100 per person) is for services to relieve pain until you can return to see your general dentist.[4] Standard plan limitations, exclusions and copayments may apply.

[1] In AZ, MD, and TX, if you do not select a dentist when you enroll, we will choose one for you.

[2] If you have not yet been assigned to a DeltaCare USA general dentist, you can do so by visiting any DeltaCare USA general dentist that is accepting new patients. When your selected dentist files a qualifying claim, you will be added to their roster and they will become your assigned DeltaCare USA general dentist. Once assigned, you must visit this dentist for future visits to receive benefits. Dependent children under the age of 14 may obtain covered care from an in-network pediatric dentist without referral from a general dentist.

[3] State-specific minimum distance requirements may apply.

[4] In TX, there is no limit on the number of miles or on the dollar amount per emergency.

We make it easy for you!

There are no exclusions for most pre-existing conditions, except work in progress.[5] Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

Glossary

Here are some common terms that will help you understand your plan:

Authorization: The process by which Delta Dental determines whether a procedure or treatment is a referable benefit under your plan. Your assigned general dentist must obtain prior authorization from us to refer you to an out-of-network specialist or out-of-network orthodontist. Services performed by an out-of-network dentist, specialist or orthodontist that are not authorized by us will not be covered.

Copayment, or copay amount: The fixed dollar amount a member is responsible for when receiving treatment.

DeltaCare USA dentist: A dentist who is a member of the DeltaCare USA network. These dentists have contracted with Delta Dental and agreed to accept negotiated fees for the services provided to DeltaCare USA members. You must visit a DeltaCare USA dentist to receive plan benefits.

Diagnostic and preventive services: A category of dental services that includes benefits for oral evaluations, routine cleanings, x-rays and fluoride treatments. There are low or no copayments for these services to encourage you to seek regular care and prevent problems from developing.

Effective date: The date your dental plan becomes active. Also, the date a member becomes eligible for benefits.

Limitations and Exclusions: Limitations are usually related to a specific time or frequency — for example, a plan may cover only two cleanings in a 12-month period or one cleaning every six months. Exclusions are services not covered by a plan.

(Dental) Referral: Directing a patient to a dental specialist by a general dentist. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.[6]

Specialist services: Services performed by a dental specialist, such as oral surgery, endodontics, periodontics or pediatric dentistry. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.[6]

For more help with understanding dental terms, visit **www1.deltadentalins.com/members/glossary.html**

[5] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

[6] Dependent children covered under a DeltaCare USA plan have the option to seek dental care from a pediatric dentist through the age of 13, whether or not the child has an assigned general dentist. Referrals to visit a pediatric specialist are not required. If the pediatric dentist determines that additional specialty care is needed, they may refer pediatric patients directly to other specialists, such as an orthodontist. At age 14, covered dependent children must obtain care from their assigned DeltaCare USA general dentist.

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	No Cost
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	No Cost
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost
D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral - per quadrant	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost
D1527	Space maintainer - removable - bilateral, mandibular	No Cost
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	No Cost
D2000-D2999	**III. RESTORATIVE**	

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $125.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	No Cost
D2392	Resin-based composite - two surfaces, posterior	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D2393	Resin-based composite - three surfaces, posterior	No Cost
D2394	Resin-based composite - four or more surfaces, posterior	No Cost
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2650	Inlay - resin-based composite - one surface	No Cost
D2651	Inlay - resin-based composite - two surfaces	No Cost
D2652	Inlay - resin-based composite - three or more surfaces	No Cost
D2662	Onlay - resin-based composite - two surfaces	No Cost
D2663	Onlay - resin-based composite - three surfaces	No Cost
D2664	Onlay - resin-based composite - four or more surfaces	No Cost
D2710	Crown - resin-based composite (indirect)	No Cost
D2712	Crown - 3/4 resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal	$125.00
D2721	Crown - resin with predominantly base metal	No Cost
D2722	Crown - resin with noble metal	$125.00
D2740	Crown - porcelain/ceramic	*$125.00
D2750	Crown - porcelain fused to high noble metal	*$125.00
D2751	Crown - porcelain fused to predominantly base metal	No Cost
D2752	Crown - porcelain fused to noble metal	$125.00
D2753	Crown - porcelain fused to titanium and titanium alloys	*$125.00
D2780	Crown - 3/4 cast high noble metal	$125.00
D2781	Crown - 3/4 cast predominantly base metal	No Cost
D2782	Crown - 3/4 cast noble metal	$125.00
D2783	Crown - 3/4 porcelain/ceramic	*$125.00
D2790	Crown - full cast high noble metal	$125.00
D2791	Crown - full cast predominantly base metal	No Cost
D2792	Crown - full cast noble metal	$125.00
D2794	Crown - titanium and titanium alloys	$125.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	No Cost
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	No Cost
D2940	Placement of interim direct restoration	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	No Cost
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	No Cost
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D2983	Veneer repair necessitated by restorative material failure	No Cost
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to 1 per 24 months*	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	No Cost
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	No Cost
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	No Cost
D3331	Treatment of root canal obstruction; non-surgical access	No Cost
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	No Cost
D3333	Internal root repair of perforation defects	No Cost
D3346	Retreatment of previous root canal therapy - anterior	No Cost
D3347	Retreatment of previous root canal therapy - premolar	No Cost
D3348	Retreatment of previous root canal therapy - molar	No Cost
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	No Cost
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost
D3921	Decoronation or submergence of an erupted tooth	No Cost

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4245	Apically positioned flap	No Cost
D4249	Clinical crown lengthening - hard tissue	No Cost
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	No Cost
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	No Cost
D4270	Pedicle soft tissue graft procedure	No Cost
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	No Cost
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	No Cost
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	No Cost
D5120	Complete denture - mandibular	No Cost
D5130	Immediate denture - maxillary	No Cost
D5140	Immediate denture - mandibular	No Cost
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery .	No Cost
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .	No Cost
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	No Cost
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	No Cost
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D5512	Repair broken complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth - complete denture - per tooth	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken retentive/clasping materials - per tooth	No Cost
D5640	Replace missing or broken teeth - partial denture - per tooth	No Cost
D5650	Add tooth to existing partial denture - per tooth	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	No Cost
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	No Cost
D5710	Rebase complete maxillary denture	No Cost
D5711	Rebase complete mandibular denture	No Cost
D5720	Rebase maxillary partial denture	No Cost
D5721	Rebase mandibular partial denture	No Cost
D5725	Rebase hybrid prosthesis	No Cost
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	No Cost
D5751	Reline complete mandibular denture (laboratory)	No Cost
D5760	Reline maxillary partial denture (laboratory)	No Cost
D5761	Reline mandibular partial denture (laboratory)	No Cost
D5765	Soft liner for complete or partial removable denture - indirect	No Cost
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 **VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

D6000-D6199 **VIII. IMPLANT SERVICES - Not Covered**

D6200-D6999 **IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

- When a crown and/or pontic exceeds six units in the same treatment plan, You may be charged an additional $30.00 per unit, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

D6210	Pontic - cast high noble metal	$125.00
D6211	Pontic - cast predominantly base metal	No Cost
D6212	Pontic - cast noble metal	$125.00
D6240	Pontic - porcelain fused to high noble metal	*$125.00
D6241	Pontic - porcelain fused to predominantly base metal	No Cost
D6242	Pontic - porcelain fused to noble metal	$125.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$125.00
D6245	Pontic - porcelain/ceramic	*$125.00
D6250	Pontic - resin with high noble metal	$125.00
D6251	Pontic - resin with predominantly base metal	No Cost
D6252	Pontic - resin with noble metal	$125.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$125.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$125.00

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	$125.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$125.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$125.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$125.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	$125.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$125.00
D6720	Retainer crown - resin with high noble metal	$125.00
D6721	Retainer crown - resin with predominantly base metal	No Cost
D6722	Retainer crown - resin with noble metal	$125.00
D6740	Retainer crown - porcelain/ceramic	*$125.00
D6750	Retainer crown - porcelain fused to high noble metal	*$125.00
D6751	Retainer crown - porcelain fused to predominantly base metal	No Cost
D6752	Retainer crown - porcelain fused to noble metal	$125.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	*$125.00
D6780	Retainer crown - 3/4 cast high noble metal	$125.00
D6781	Retainer crown - 3/4 cast predominantly base metal	No Cost
D6782	Retainer crown - 3/4 cast noble metal	$125.00
D6783	Retainer crown - 3/4 porcelain/ceramic	*$125.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$125.00
D6790	Retainer crown - full cast high noble metal	$125.00
D6791	Retainer crown - full cast predominantly base metal	No Cost
D6792	Retainer crown - full cast noble metal	$125.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	No Cost
D7252	Partial extraction for immediate implant placement - *Once in a lifetime*	No Cost
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	No Cost
D7280	Exposure of an unerupted tooth	No Cost
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	No Cost
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments

D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The Benefit for pre-treatment records and diagnostic services includes:	$250.00
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	
D0322	Tomographic survey	
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D intraoral surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	
	The Benefit for post-treatment records includes:	$100.00
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$950.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$950.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,300.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,300.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,400.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - *adults, including covered dependent adult children*	$1,610.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$250.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$175.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost

S-A-CA-STD10-R20 CA41R - V25

Plan CA41R	DeltaCare USA	Description of Benefits and Copayments
D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	No Cost
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	No Cost
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	No Cost
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review .	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

Procedures with age restrictions will be subject to exceptions based on medical necessity.

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services must be referred by the Contract Dentist. You pay the copayment specified for such services.

S-A-CA-STD10-R20

CA41R - V25

Limitations and Exclusions of Benefits

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional $125.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
4. Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the Plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service department at 800-422-4234 if you have questions regarding the additional fee or name brand services.
5. Benefits provided by a pediatric Dentist are limited to children through age 13, less applicable Copayments. The Plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.
6. The cost to You for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.
7. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous dental plan, as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
8. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You, unless coverage is required under other law.
9. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).
10. X-ray Limitations:
    - When the frequencies for the comprehensive radiographic images (D0210) and panoramic images (D0330) differ, the least restrictive frequency will apply.
    - Panoramic images are not considered part of a comprehensive intraoral series.
    - Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
    - Bitewing x-rays are limited to two images for under age 10.
    - Image capture procedures are not separately billable services.

S-B-CA-STD10-R24 V25

Limitations and Exclusions of Benefits

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch).
4. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
6. Procedures, appliances or restorations if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures D9951 and D9952 as shown on Schedule A.
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations or other diagnostic services for non-covered benefits.
10. Dental services received from any dental facility other than the Contract Dentist or a preauthorized dental specialist (oral surgeon, endodontist, periodontist, pediatric Dentist or Contract Orthodontist) except for *Emergency Services* as described in the Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription and over-the-counter drugs.
13. Dental expenses incurred in connection with any dental procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies with the exception of procedures D9944 (Occlusal guard - hard appliance, full arch), D9945 (Occlusal guard - soft appliance, full arch) and D9946 (Occlusal guard - hard appliance, partial arch);
16. Treatment or appliances that are provided by a Contract Dentist whose practice specializes in prosthodontic services.
17. Orthodontic treatment must be provided by a licensed Dentist.
18. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
19. Services or supplies for sleep apnea.

S-B-CA-STD10-R24 V25

More helpful tips for using your plan

Find a network dentist near you

Use our convenient **Find a dentist** tool and select **DeltaCare USA** as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Create an online account at deltadentalins.com/welcome

- Review your plan benefits
- Access your ID card if you want one (You do not need an ID card to receive services.)
- Select or change your dentist at any time

Enjoy the perks of Delta Dental coverage

Get extra member perks like oral and overall health savings, exclusive resources and more at **www1.deltadentalins.com/memberperks**.

You can also get oral health tools and tips at **deltadentalins.com/wellness**.

Contact us

Need help? Let us know.

Online: Visit **deltadentalins.com/contact**

Write to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234

Customer Service agents are available Monday through Friday, 8 am to 9 pm ET. Or, use our automated phone system, available 24/7.

Administered by:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

NOTE: This is only a brief summary of your plan.

This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the "Description of Benefits and Copayments" and "Limitations and Exclusions of Benefits" in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at **800-422-4234**.

Delta Dental PPO Plan Orthodontic Coverage
For County of Alameda Enrollees*

Orthodontic treatment is covered for Delta Dental PPO participants. Delta Dental will pay 50% of the cost up to a $2,500 lifetime maximum for adults and children.

1. **How can I find an orthodontist?**
   You can visit any licensed orthodontist under your plan; however, your costs will usually be lower if you choose a Delta Dental PPO orthodontist. Use the "Find a Dentist" tool at deltadentalins.com (or the mobile app) and enter "orthodontist" in the keyword field.

2. **Who's covered for orthodontia**
   The plan covers the enrollee and all covered dependents.

3. **What's covered?**
   The plans covers 50% of orthodontic services such as braces up to a lifetime maximum of $2500 per individual.

   Note: If you are transitioning from the County of Alameda DeltaCare USA Plan, you will not receive a new lifetime maximum. The plan liability will be based on the previously established fee arrangement with your provider. Your lifetime maximum will be coordinated with payments made under the DeltaCare USA plan.

4. **Are retainers covered?**
   Typically one set of post-treatment retainers (for orthodontic purposes) is covered in a lifetime.

5. **Is Invisalign® covered?**

   The plan pays the cost of standard braces toward the cost of Invisalign. Depending on your dentist's contract fees for orthodontia, you may be required to pay additional out-of-pocket costs for Invisalign. If you're interested in Invisalign, ask your dentist to submit a pre-treatment estimate before treatment begins.

6. **How much does orthodontic treatment cost?**
   Costs depend on the services you need, but Delta Dental can help estimate costs before treatment begins. Ask your dentist to submit a pre-treatment estimate to Delta Dental, and we'll send you an overview of the total treatment cost, including how much your plan pays and your share of the cost. All Delta Dental dentists and orthodontists agree to submit claims and pre-treatment estimates upon your request.

7. **If I began treatment under a different dental plan, is work in progress covered?**
   Work in progress coverage may be available if you are undergoing active orthodontic treatment. Ask your orthodontist to submit an Orthodontic Treatment Claim to Delta Dental, including:
   - All charges and fees (including the down payment or installments paid by your previous dental plan)
   - Banding date and length of active treatment
   - Brief description of the dentition, appliance (including type) and treatment
   - If you are covered by more than one plan, information about the secondary carrier

Orthodontic treatment in progress is prorated based on the initial *date of service*. Banding charges and monthly fees incurred prior to the effective date of your Delta Dental plan are subtracted from the total amount of the claim in order to determine the benefit. Delta Dental will commence payments on remaining amounts, up to your PPO lifetime maximum.

Note: If you were previously covered under the DeltaCare USA plan offered by the County of Alameda, treatment paid by Delta Dental PPO will be based on the previously agreed upon treatment plan not to exceed your lifetime maximum. Your copayment may increase if you dental office modifies their fees based on their Delta Dental PPO contact arrangements. You may want to consider remaining in the DeltaCare USA plan until your orthodontic treatment is completed to avoid additional costs.

8. **How are orthodontic claims paid under the PPO plan?**
   Delta Dental pays the contracted dentist directly. If you seek services from a non-contracted dentist, Delta Dental will pay you directly.
   - When Delta Dental's total payment is less than $500, Delta Dental makes a lump sum payment at the time a claim is received for the services in progress.
   - When Delta Dental's total payment is $500 or more, Delta Dental will make two equal payments, one at the time the claim is received and a second 12 months later, not to exceed your plan's orthodontic lifetime maximum.

9. **Are claims required for orthodontic treatments?**
   Yes, Delta Dental orthodontists will submit claims for you. If you choose a non-Delta Dental orthodontist, you may need to pay the orthodontist at the time of your appointment and submit a claim to us to request reimbursement.

10. **Is my treatment subject to both the orthodontic lifetime maximum and regular annual maximum?**
    Orthodontic services are subject to the orthodontic lifetime maximum only. However x-rays and certain tooth extractions associated with your treatment may be covered under your Basic benefits and subject to your regular annual maximum.

11. **What if I have dual coverage for orthodontia with another dental plan?**
    Ask your dental office to submit a claim form and include the other plan information and the amount paid by the other plan. Eligibility will be based on the birthday rule. If you and your covered spouse both have dental plans, your dependent children's primary plan is under the plan of the parent with the earliest birth month in the year.

*Does not include Deputy Sheriff Association (DSA) plans or Supplemental Spousal Plans

DELTA DENTAL

Delta Dental PPO™

Go Paperless

View your documents online

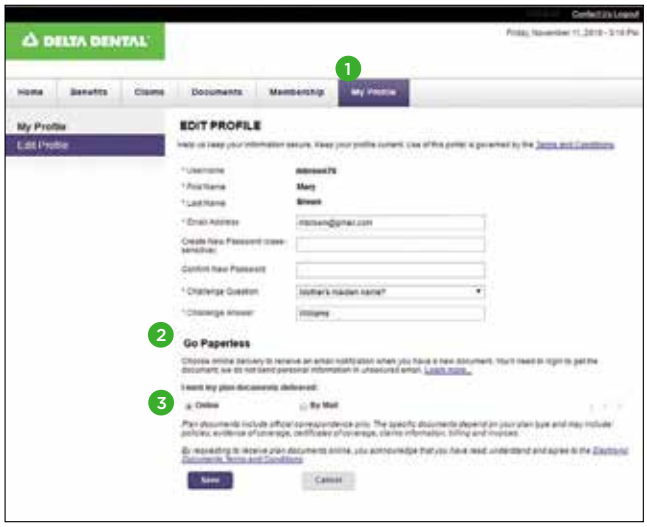
Why go paperless?

- **It's convenient.** Get your claim statements and other important plan documents online. You'll receive an email alert when a new document is available.
- **It saves paper.** You'll reduce your ecological footprint.
- **It's faster.** No need to wait for documents to arrive in the mail.
- **It's easy.** Updating your settings takes only a few minutes.

How do I change my settings?

Visit **deltadentalins.com/coa**. Log in to your account. (If you don't already have one, click **Register Today** to sign up.)

1. Click the **My Profile** tab.
2. Go to the **Go Paperless** section.
3. Select **Online** and click **Save**.



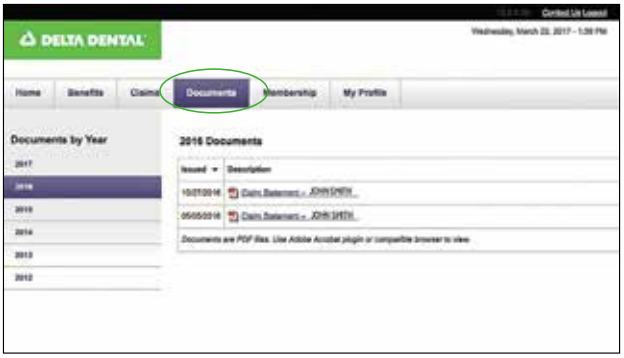
See the next page to learn how to download and read your electronic claim statements.

deltadentalins.com/coa

Where can I find my claim statements?

To view your claim statements as PDFs, simply log in to your online account.

1. Go to **deltadentalins.com/coa**. Log in.
2. Click **Documents** tab at the top.
3. Choose the claim you want to view. A new window will pop up with the PDF, which you can save to your desktop for reference. (If the window doesn't pop up, make sure that your browser hasn't disabled pop-ups.)



You can also click the **Claims** tab to see claim information, but you can't download the statement as a PDF document.

What's in my claim statement?

#1 Claim number: 20160255494511

PROCEDURE NUMBER AND TYPE OF SERVICE	A SUBMITTED FEE ($)	B ACCEPTED FEE ($)	C MAXIMUM CONTRACT ALLOWANCE ($)	D AMOUNT APPLIED TO DEDUCTIBLE ($)	E PAID BY ANOTHER PLAN ($)	F CONTRACT BENEFIT LEVEL	G DELTA DENTAL PAYS ($)	H PATIENT PAYS ($)
Date of service: January 1, 2016 Treatment type: Restorative (D2393) RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR TOOTH Tooth: 30 Surface(s): B,O	280.00	255.00	255.00	0.00	--	80% Treating provider: JANICE LEE	204.00	51.00
Date of service: January 1, 2016 Treatment type: Restorative (D2393) RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR TOOTH Tooth: 31 Surface(s): D,O	280.00	255.00	255.00	0.00	--	80% Treating provider: JANICE LEE	204.00	51.00
Claim total for JOHN SMITH	**560.00**	**510.00**	**510.00**	**0.00**	**0.00**		**408.00**	**102.00**

A. **Submitted fee:** The amount charged by the dental office.

B. **Accepted fee:** The total owed to the dentist, including your share and the amount paid by your dental plan.

C. **Maximum contract allowance:** The total on which Delta Dental bases its payment portion.

Note: If you go to an out-of-network dentist, this amount may be lower than the accepted fee.

D. **Amount applied to deductible:** How much of your deductible you have fulfilled with the given procedure(s).

Note: Not all plans include a deductible (a fixed dollar amount you're required to pay before your coverage applies).

E. **Paid by another plan:** The amount covered by your primary plan, if you have dual coverage.

Note: This column only applies if Delta Dental is your secondary plan (such as coverage through your spouse or second job).

F. **Contract benefit level:** The percent of the maximum contract allowance that's paid by your dental plan.

G. **Delta Dental pays:** How much your dentist is paid by your dental plan.

H. **Patient pays:** How much you owe the dentist. This is what's left over from the accepted fee after your insurance covers its portion(s). If you've already paid this amount to the dentist, you're good to go.

DELTA DENTAL

Smiles All Around

6 essential steps for your dental routine

1 Gather your tools.
Make sure you have fluoride toothpaste, dental floss and a toothbrush with soft, rounded bristles.

2 Set a schedule.
Brush at least twice a day, and floss at least once. When possible, brush immediately after eating sweet or starchy foods, but wait half an hour after eating acidic foods to avoid damaging your softened enamel.

3 Be thorough.
Brush for at least two minutes each session, angling your toothbrush at 45 degrees and using short, circular strokes. Apply just enough pressure to feel the bristles without squishing them. When you're done, brush your tongue to remove bacteria.

4 Don't forget to floss.
Floss removes plaque from between teeth and below the gumline. Don't worry if your gums feel tender or bleed at first. By flossing, you're fighting the source of the problem: the bacteria causing your sensitive gums.

5 Rinse to refresh.
After brushing and flossing, vigorously rinse your mouth with mouthwash or water to remove any loosened plaque and food particles.

6 Go pro.
Regular dental cleanings are an important part of maintaining your oral and overall health. Call your dentist for an appointment today.

Oral health is essential at every stage of life. Turn the page to learn more.

deltadentalins.com/enrollees

Frequently Asked Questions

What you need to know about your DeltaCare USA plan

Getting started

1. **How do I enroll in a DeltaCare USA plan?**
   Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. **How do I get started using my DeltaCare USA plan?**
   Once we process your enrollment, we'll mail you welcome materials that will include:

   - **The name, address and phone number of your selected primary care dentist.** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
   - **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
   - **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.

3. **How long will it take to get an appointment with my primary care dentist?**
   Two to four weeks[1] is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time slot, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. **How much will my dental treatments cost? How do I pay?**
   With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

5. **How do I select my primary care dentist?**
   When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at **deltadentalins.com** and select the DeltaCare USA network. If you do not select a dentist when you enroll, we will choose one for you.

6. **Does everyone in my family have to choose the same primary care dentist?**
   No. Each family member can select his or her own primary care network dentist.[2]

7. **Can I change my primary care dentist?**
   Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or contact Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

[1] In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[2] In MA, you cannot select more than three primary care dentist facilities per family.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists. You must visit your selected primary care network dentist to receive benefits under this plan.

9. **What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

10. **If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles from your primary care dentist. Your out-of-area emergency benefit (typically limited to $100 per person) is for services to relieve pain until you can return to your primary care network dentist.[3] Standard plan limitations, exclusions and copayments may apply.

11. **Can I access my plan online?**
Yes. Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress[4]), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

13. **Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.

14. **Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.

15. **What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

[3] In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[4] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

Delta Coverage Highlights

The following information is only a summary. Once you select the plan that is right for you and your family, be sure to read the plan's Evidence of Coverage (EOC) booklet for details on how to select a dentist, what services are included, and your costs and copays, if any. The EOC can be found on the EBC online.

Plan Features*	DeltaCare USA	DeltaDental PPO		Delta PPO Supplemental Plan (Dual-County Employee Plan)
		PPO	Non-PPO	
About the Plan	Generally lower out-of pocket costs than the PPO, but a more limited provider network. No out-of-network benefits.	Ability to see any provider, though your share of the charges will be lower if you see a Delta Dental PPO provider.		If you and your spouse/ domestic partner, and/or Young Adult Dependent (YAD) up to age 26, are employed by the County **and** enrolled in the County's Delta Dental PPO Plan, you can take advantage of the **Delta Dental PPO Supplemental Dental Plan.** This plan supplements the Delta Dental PPO plan by adding up to an additional 25% coinsurance on your Delta Dental PPO Plan for benefits provided to the spouse/ domestic partner/ YAD as eligible dental expenses are incurred throughout the year. The annual maximum is $600. **Important Note: You should not enroll in this plan if you are not covered by the County Delta Dental PPO Plan under another related County employee.** **To participate, one employee selects self+1 or family coverage, and the employee's spouse/ domestic partner selects the supplemental plan with self+1 or family coverage.**
Your Dental Provider	• You select a primary care dentist from the DeltaCare USA network. • If you need a dental specialist, your DeltaCare dentist will make the referral for you.	Go to any Delta Dental PPO dentist.	Use any licensed dentist, including Delta Dental Premier dentists. When you visit a non-contracted dentist and the cost exceeds the Maximum Plan Allowance, (MPA) you pay the difference.	
Annual Deductible	No deductible	$45 per person	$45 per person	
Annual Maximum Benefit	No annual or lifetime maximum	From $1,550 to $1,900 per person[1]		
Preventitive Care • Exam • Cleaning • Routine X-ray • Flouride treatment	Plan generally pays 100%, but some services may require a copay. Please see EOC document.	Plan pays 100% with no deductible	Plan pays 100% of Delta Dental Premier dentist's fee or MPA. No deductible.	
Basic Care • Fillings • Extractions • Root canal therapy • Periodontics	Plan generally pays 100%, but some services may require a copay. Please see EOC document.	Plan plays 85% after deductible	Plan plays 80% of Delta Dental Premier dentist's fee or MPA after deductible	
Major Care • Crowns • Inlays • Bridges • Dentures	Plan generally pays 100%, but some services may require a copay. Please see EOC document.	Plan pays 80% after deductible, includes coverage for implants	Plan pays 80% of Delta Dental Premier dentist's fee or MPA after deductible, includes coverage for implants	
Orthodontia (adult and child)	Covered with a copay, which varies by treatment. Please see EOC document.	• $2,500 lifetime maximum per person[2] • Plan pays 50% of cost up to maximum • Deductible does not apply		
Other	• Implants are not covered • Mouth guards are covered	TMJ and Mouth guards are covered at 60%	TMJ and mouth guards are covered at 60% of the Delta Dental dentist's Premier fee or MPA after deductible	

* If there is any conflict between the information in this summary and the Plan's EOC, the EOC determines benefits provided.

[1] While most employees have a $1,900 annual maximum, some employees have $1,550, $1,650, and $1,750 annual maximum. Check your Memorandum of Understanding or Administrative Code (if unrepresented), to see which maximum applies to you.

[2] Orthodontia Lifetime maximum for DSA and ACMEA Sheriff's Management is $3,000 per person.

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and County of Alameda. Take a look at your VSP vision care coverage.

VSP members save an annual average of **$489***

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe Calvin Klein COLE HAAN
DRAGON. FLEXON LONGCHAMP PARIS
and more

Up to 40% savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Enroll through your employer today.
Questions?
vsp.com or
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during an eye exam.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Save up to $250 on Featured Frame Brands when you shop on Eyeconic®, the VSP preferred online eyewear store.

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details. *Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.
Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through County of Alameda. Get coverage for essentials, or upgrade to enhance your coverage options.

Provider Network:
VSP Choice
Effective Date:
02/01/2026

vsp vision care

BENEFIT	DESCRIPTION	COPAY
PLUS PLAN Coverage with a VSP Doctor		
WELLVISION EXAM®	• Focuses on your eyes and overall wellness • Routine retinal screening • Every plan year[1]	$15 for exam and glasses Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		
FRAME+	• $170 Featured Frame Brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club frame allowance • $80 Costco frame allowance • Every other plan year	Combined with exam
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every plan year	Combined with exam
LENS ENHANCEMENTS+	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every plan year	$0 $95 – $105 $150 – $175
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
VSP COMPUTER VISIONCARE℠ **PLAN**		
COMPUTER VISION EXAM	• Evaluates your needs related to computer use • Every plan year	$15 for exam and glasses
FRAME+	• $110 Featured Frame Brands allowance • $90 frame allowance • 20% savings on the amount over your allowance • Every other plan year	Combined with exam
LENSES	• Single vision, lined bifocal, lined trifocal, and occupational lenses • Every plan year	Combined with exam
VSP LIGHTCARE™+	• $150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every other plan year	Combined with exam

BENEFIT	DESCRIPTION	COPAY
PREMIUM PLAN Coverage with a VSP Doctor		
WELLVISION EXAM®	• Focuses on your eyes and overall wellness • Routine retinal screening • Every plan year[1]	$15 for exam and glasses Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		
FRAME+	• $270 Featured Frame Brands allowance • $250 frame allowance • 20% savings on the amount over your allowance • $250 Walmart/Sam's Club frame allowance • $135 Costco frame allowance • Every plan year	Combined with exam
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Every plan year	Combined with exam
LENS ENHANCEMENTS+	• Standard progressive lenses • Premium/Custom progressive lenses • Anti-glare coating • Impact-resistant lenses • Tints/Light-reactive lenses • Average savings of 30% on other lens enhancements • Every plan year	$0 $25 $25 $0 $0
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
VSP COMPUTER VISIONCARE℠ **PLAN**		
COMPUTER VISION EXAM	• Evaluates your needs related to computer use • Every plan year	$15 for exam and glasses
FRAME+	• $110 Featured Frame Brands allowance • $90 frame allowance • 20% savings on the amount over your allowance • Every plan year	Combined with exam
LENSES	• Single vision, lined bifocal, lined trifocal, and occupational lenses • Every plan year	Combined with exam
VSP LIGHTCARE™+	• $250 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every plan year	Combined with exam

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50
Frame ..... up to $70
Single Vision Lenses ..... up to $40
Lined Bifocal Lenses ..... up to $60
Lined Trifocal Lenses ..... up to $80
Progressive Lenses ..... up to $60
Contacts ..... up to $130

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50
Glasses ..... up to $200
Contacts ..... up to $200

PLEASE NOTE: Your eligibility for benefits will follow the frequency of your newly elected plan. For example, if you had the Premium plan and received frames in 2024, and elected the Plus Plan for 2025, you are not eligible for frames until 2026. Log in to vsp.com to review your benefits.

alameda county

Human Resource Services

Our community. Your purpose.