State-Specific Notices

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

California

Important Notice to Subscribers of UnitedHealthcare Benefits of California

Appealing a Health Care Decision

How to Dispute a Determination

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

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

There are two types of grievances: Standard and Expedited

Standard Grievance Process

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

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

Expedited/72 hour Grievance Process

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

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

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

For an Expedited Grievance:

- **Call: UnitedHealthcare Benefits Plan of California Customer Service at 1-800-260-2773 or TTY/RTT/TDD 711.** UnitedHealthcare Benefits Plan of California will document and process your grievance.

- **Write:** UnitedHealthcare Benefits Plan of California
  Attention: Expedited Member Appeals
  P.O. Box 30573
  Salt Lake City, UT 84130-0573
  Expedited Fax: 1-801- 994-1083

Simultaneous Appeal

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

Department of Managed Health Care Complaint Process

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **UnitedHealthcare Benefits Plan of California at 1-800-260-2773 and the hearing and speech impaired may call TTY/RTT/TDD 711**, and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **https://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Availability of Consumer Assistance Services

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

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

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

Important Notice to Subscribers of UnitedHealthcare Insurance Company in California

Claim Disputes

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

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

Call the California Department of Insurance at:

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

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

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

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

Timely Access to Care

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

For Medical Services, appointment wait times are as follows:

- Emergency health services are available and accessible within the plan's service area 24 hours, 7 days a week. Ambulance services for the service area served by the plan for transportation to the nearest 24-hour facility with physician coverage.
- Urgent health care services that do not require prior authorization are offered within 48 hours of the request. Urgent health care services that require prior authorization are offered within 96 hours of the request.

- Non-urgent care primary care and non-urgent, non-physician mental health services are offered within 10 business days of the request.

- Non-urgent specialist care and ancillary services (i.e. vision care services) are offered within 15 business days of the request.

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

- Emergency services: 24 hours

- Urgent appointments: within 72 hours of the time of request for appointment

- Non-urgent and preventive dental care appointments: within 14 business days

Telephone Triage/Nurse Lines

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

Language Assistance

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

Network Provider Accessibility Complaints

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

Call the California Department of Insurance at:

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

- 213-897-8921 if the Covered Person resides outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Colorado

Important Notice to UnitedHealthcare of Colorado, Inc. Subscribers

Operations

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

Organizational Structure

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

UnitedHealthcare of Colorado, Inc. Financial Information as of December 31, 2020

Balance Sheet:
Assets: $52,826,818
Liabilities: $32,929,106
Net Worth: $19,897,712
Total Net Worth/Liabilities: $52,826,81

Income Statement:
Revenue: $102,823,309
Medical Expenses: $79,298,721
Administration: $21,390,341
Total Expenses: $100,689,062
Provisions for Income Tax: $864,510
Income: $1,454,065

Quick Reference Guide

If you need:

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

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

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

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

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

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

Connecticut

Important Notice to Connecticut Plan Subscribers

Health Care Services from Out-of-Network Providers

For plans that contain Network and Out-of-Network benefits:
You may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network providers if (i) you are diagnosed with a condition or disease that requires specialty care and we do not have a Network provider with the required specialty training within our Network; or (ii) a participating provider is not available to provide the covered benefit without unreasonable travel or delay. In this situation, you may contact us at the telephone number on your ID card, or your Network provider can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network provider to coordinate care through an Out-of-Network provider. If your care is coordinated through an Out-of-Network provider, Covered Health Care Services will be paid as Network Benefits.

For plans that only contain Network benefits:
You may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network providers if (i) you are diagnosed with a condition or disease that requires

specialty care and we do not have a Network provider with the required specialty training within our Network; or (ii) a participating provider is not available to provide the covered benefit without unreasonable travel or delay. In this situation, you may contact us at the telephone number on your ID card or your Network provider can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network provider to coordinate care through an Out-of-Network provider.

Florida

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

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

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

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

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

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

Your Rights Under Mental Health Parity Laws

This plan is subject to state and federal Mental Health Parity laws, which generally prohibit insurance plans from providing mental health or substance use disorder benefits in a more restrictive manner than other medical benefits. View Federal Mental Health Parity and Addiction Equity Act standards and requirements at https://www.uhc.com/legal/required-state-notices/florida.

If you believe UnitedHealthcare standards or practices relating to the provision of mental health or substance use disorder benefits are not compliant with applicable mental health parity laws, you or an authorized representative may submit a complaint to the Division of Consumer Services:

Online: https://www.myfloridacfo.com/Division/Consumers/needourhelp.htm

Email: Consumer.Services@myfloridacfo.com

Telephone: in-state: toll-free 1-877-MY-FL-CFO (1-877-693-5236) out-of-state: (850) 413-3089

For more mental health benefit information, please refer to your Certificate of Coverage (COC) and Schedule of Benefits or call the toll-free member phone number on your health plan ID card.

Hawaii

Important Notice to UnitedHealthcare Members in Hawaii

Orthodontic Services for Treatment of Orofacial Anomalies

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

Illinois

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

Dependent Coverage

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

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

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

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

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

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

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

Your Heart Health

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

"Life's Simple 7"

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

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

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

Kentucky

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

Your Appeal Rights Under Kentucky State Law:

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

Availability of Financial Statement:

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

Louisiana

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

Louisiana Balance Billing Disclosure Member Notice

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

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

Maine

Important Notice for Maine Plan Subscribers and Residents

Coverage for Reconstructive Surgery after Mastectomy

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

Benefits include medically appropriate inpatient coverage following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer including breast reconstruction

procedures for the period of time determined by the attending Physician in consultation with the Covered Person.

Comparable Health Care Services Incentive program

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

Massachusetts

Important Notice to UnitedHealthcare Members in Massachusetts

Your Rights Under Mental Health Parity Laws

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

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

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

Gender Discrimination Notice

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

How To Obtain a Binding Estimate

Massachusetts law allows insured members of Massachusetts based health insurance plans to contact their health insurance carriers to request a binding estimate of the cost of certain health care services. If you desire such an estimate, contact Consumer Services at the number on the back of your ID card. The amount you will be provided is only an estimate and it is good for 90 days. The cost of a service can change based on your medical condition at the time of the service and could be affected by services being performed that were not part of the original estimate. Specific cost estimates are not available pre-service for anesthesia or facility charges.

You could be responsible for payment of services your health plan does not cover. The true payment and charges will be determined when the claim is filed. Please note that the cost estimator tool on **myuhc.com** is not intended to be, and should not be relied upon, for obtaining the binding cost estimate that Massachusetts law allows insured members to request.

Radiologic Imaging Service

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

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

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

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

Surgical Services

Certain surgical procedures, when performed in a hospital outpatient location, may not be considered "medically necessary." There are some exceptions to this, but if you receive a letter that says your surgical procedure will not be covered because it will be performed in a hospital outpatient location and that service site is not medically necessary, you may have the option of selecting an ambulatory service center for the service.

You can do the following to find a covered ambulatory service center location, to perform the surgical procedure:

1. Log in at **myuhc.com** and click on Find a Care & Costs. Next, click on the Medical Directory and choose places then, Specialty Centers, and finally Ambulatory Surgery Centers. Refine your results by adjusting the location, distance, freestanding facility and type of specialty needed for your care.

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

You may also be contacted by email, phone call or text, to inform you that the service will not be covered unless you select an ambulatory surgery center. The outreach will direct you to a website or customer service where we will help you find a covered location.

Mid-Atlantic States

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

UnitedHealthcare of Mid-Atlantic, Inc.

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

   Statutory Financial Report for UnitedHealthcare of Mid-Atlantic, Inc. for the Twelve Months Ended December 31, 2020

Item	Amount
Revenue	$2,113,162,930
Medical Service Expenses	$1,734,692,643
Gross Margin	$378,470,287
Administrative Expenses	$224,258,701
Investment and Other	$6,195,768
Net Income Before Taxes	$160,407,354
Income Tax Incurred (Benefit)	$40,241,736
Net Income	$120,165,618

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

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

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

5. 95.0% of UHCMA Maryland membership is enrolled in our Medicaid product and is assisted by public funds.

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

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

8. 81.3% of UHCMA Virginia membership is enrolled in our Medicaid product and is assisted by public funds.

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

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

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

   Statutory Financial Report for Optimum Choice, Inc. for the Twelve Months Ended December 31, 2020

Revenue	$265,468,934
Medical Expenses	$204,724,297
Gross Margin	$60,744,637
Administrative Expenses	$51,881,029
Investment and Other	$2,240,597
Income Before Taxes	$11,104,205
Income Tax	$3,308,124
Net Income	$7,796,081

   Statutory Financial Report for MD - Individual Practice Association, Inc. for the Twelve Months Ended December 31, 2020

Revenue	$225,782,625
Medical Expenses	$171,321,162
Gross Margin	$54,461,463
Administrative Expenses	$15,767,063
Investment and Other	$150,588
Income Before Taxes	$38,844,988
Income Tax	$9,123,894
Net Income	$29,721,094

2. Individual products were not offered for 2020.

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

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

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

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

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

NOTICE FOR DELAWARE SUBSCRIBERS:

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

- Coverage for dependents, as defined by state law, until the dependent's twenty-sixth birthday.

- For plans that provide coverage for other prosthesis, coverage shall include scalp hair prosthesis worn for hair loss suffered as the result of alopecia areata, resulting from an autoimmune disease.

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

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

NOTICE FOR MARYLAND SUBSCRIBERS:

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

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

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

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

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

Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance

Please refer to your Certificate of Coverage (COC) and Schedule of Benefits, or contact UnitedHealthcare at the number on your health plan ID card for full mental health benefit information, including at least the following:

- Inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits
- Partial hospitalization benefits
- Outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes

In addition, you may refer to the Maryland Insurance Administration website: www.insurance.maryland.gov.

Maryland Proposed Rate Increase Information Notice

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

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

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

Physician Compensation Disclosure

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

Claims Submissions

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

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

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

NOTICE FOR VIRGINIA SUBSCRIBERS:

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

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

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

NOTICE FOR WEST VIRGINIA SUBSCRIBERS:

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

- Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists.
- A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen or over.
- A test for the human papilloma virus (HPV) for women age eighteen or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen and over.
- Rehabilitation services, which includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status.
- Child immunization services, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration.
- Emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition.
- Colorectal cancer screening for a nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy.
- Any covered person diagnosed with diabetes has the right to direct access to an eye care provider of their choice from the insurer's panel of providers for an annual diabetic retinal examination.

- A female enrollee has the right to direct access to a women's health care provider of her choice for a well woman examination.
- Reconstruction of the breast following mastectomy; or reconstructive or cosmetic surgery required as a result of an injury caused by an act of family violence as defined by state law, when the person inflicting the injury was convicted of a felony, a lesser included misdemeanor offense, or a charge of domestic battery for inflicting the injury.

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

New Hampshire

Important Notice for New Hampshire Plan Subscribers and Residents

Continuation of Coverage Rights

If your coverage ends under the policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or New Hampshire state law. For further information about your federal and state continuation of coverage rights, please refer to your Certificate of Coverage.

For a detailed summary of your current continuation of coverage rights under New Hampshire law, visit https://www.uhc.com/legal/required-state-notices/new-hampshire.

Out-of-Network Services

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

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

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

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

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

New Jersey

Important Notice to UnitedHealthcare Subscribers in New Jersey

Independent Consumer Satisfaction Survey results

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

Office of Health Care Quality Assessment
New Jersey Department of Health
P.O. Box 360
Trenton, NJ 08625-0360
609-984-7334

Managed Health Care Consumer Assistance Program

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

Standards for Access to Service

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

Organ Donation

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

Member Rights and Responsibilities

As a Member you have the following rights:

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

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

   Finally, you have the right to refuse treatment to the extent permitted by law. We and your Network Provider will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and We and your Network

Provider believe no professionally acceptable alternative exists, We will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

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

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

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

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

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

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

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

8. The right to initiate dis-enrollment from the Plan.

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

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

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

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

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

New Jersey and New York

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

Overview of Provider Reimbursement Methodologies

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

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

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

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

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

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

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

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

Pharmacy - We have entered into an arrangement with a national pharmacy benefit management company that, in turn, contracts with pharmacies to provide pharmacy products and services to members. The pharmacies are paid for the prescription drug products they dispense to members and they receive a fee for dispensing the prescriptions. The pharmacy

benefit management company also provides certain administrative services in connection with administration of UnitedHealthcare pharmacy benefits. UnitedHealthcare may contract with pharmacies known as “specialty” pharmacies to provide certain pharmaceuticals, such as infertility drugs.

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

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

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

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

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

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

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

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

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

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

Ohio

Important Notice to UnitedHealthcare of Ohio, Inc. Subscribers

Annual Statement for the Health Plan

As a health-insuring corporation (HIC) regulated by the Ohio Department of Insurance, UnitedHealthcare of Ohio, Inc. must comply with certain rules and regulations. Such compliance includes making available the following information annually for our plan customers. UnitedHealthcare of Ohio, Inc. serves plan customers in all 88 Ohio counties. As of December 31, 2020, the HIC was providing health care benefits to 94 employer groups and more than 3,077 plan customers. UnitedHealthcare of Ohio's parent company and affiliates also provide or administer other types of health benefits plans, bringing the total number of customers served in Ohio to 504,192.

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

- Executive offices are located at 5900 Parkwood Place, Dublin, OH 43016.

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

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

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

More than 50,000 physicians and allied health professionals, 2,390 pharmacies, and 236 acute hospitals were under contract with UnitedHealthcare in Ohio as of December 31, 2020. Physicians are primarily reimbursed on a fee-for-services basis. Reimbursements to hospitals and other health care providers is dependent on the negotiated terms of individual contracts. Each UnitedHealthcare plan customer receives a listing of network physicians and health care providers. These provider listings are updated twice a year – spring/summer and fall/winter. If you have questions about a contracted physician's or health care provider's hours, please call the physician's or health care provider's office directly. If you do not have the latest information and need a current listing, call the member phone number on your health plan ID card.

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

Oklahoma

Important Notice to UnitedHealthcare Subscribers in Oklahoma

Wigs/Scalp Prosthesis

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

Maternity

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

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

Oklahoma Breast Cancer Patient Protection Act

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

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

1. Reconstruction of the breast on which the mastectomy has been performed; and

2. Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance.

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

Oregon

Important Notice for UnitedHealthcare Subscribers in Oregon

Confidential Communication Law

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

(a) Submit the standardized form entitled “Oregon Confidential Communication Request” which can be found on the Oregon Insurance Division website of the Department of Consumer and Business Services at www.insurance.oregon.gov. Find the form at https://dfr.oregon.gov/help/Documents/5059.pdf

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

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

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

Hearing Loss Resources

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

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

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

Rhode Island

Important Notice for UnitedHealthcare Subscribers in Rhode Island

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

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

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

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

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

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

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

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

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

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

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

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

Right to Designate a Primary Care Physician

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

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

Texas

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

Notice of Coverage for Acquired Brain Injury

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

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

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

Mastectomy or Lymph Node Dissection

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

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

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

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

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

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

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

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

Examinations for Detection of Prostate Cancer

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

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

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

Inpatient Stay following Birth of a Child

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

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

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

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

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

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

Coverage for Tests for Detection of Colorectal Cancer

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

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

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

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

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early

detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

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

Utah

Important Notice to UnitedHealthcare of Utah, Inc. Subscribers

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

Vermont

Important Notice to UnitedHealthcare Plan Subscribers that Reside in Vermont

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

Virginia

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

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

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

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

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

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

You can nominate a board member

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

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

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

Washington

Important Notice to Washington subscribers under UnitedHealthcare Insurance Company and UnitedHealthcare of Washington, Inc.

UnitedHealthcare may contract with others to help us in managing your health plan benefits. These entities are called Health Care Benefit Managers. Health Care Benefit Manager means a person or entity providing services to, or acting on behalf of, a health insurance carrier or employee benefits programs, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies. An updated listing of Health Care Benefit Managers can be found at **uhc.com/legal/required-state-notices/washington/health-care-benefit-managers**.