Evidence of Coverage comparison.

Learn about the UnitedHealthcare benefits and program enhancements between 2017 and 2019 for the state of California.

Evidence of Coverage comparison overview for brokers and employers.

In the state of California, UnitedHealthcare Insurance Company or its affiliates (UHIC) is changing its license to UnitedHealthcare Benefits Plan of California (UHCBPofCA). This Evidence of Coverage (EOC) document shows changes for plans with 51 or more employees renewing Jan. 1, 2019, and after. It provides a high-level comparison of the changes per benefit category. The benefit information provided represents UnitedHealthcare California state standards.

UnitedHealthcare®

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California UHIC/UHCBP Certificate and Disclosure Documents Comparison Summary

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Nomenclature Change

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Certificate of Coverage (COC)	Combined Evidence of Coverage (EOC)

Cover Page and Introductory Matter

UHIC 2017 LG COC	UHCBP 2019 LG EOC
CDI contact information on cover.	DMHC contact listed in *Section 6: Questions, Complaints and Appeals*, under the *Review by the Department of Managed Health Care section* (pg. 76) of *The 2019 UHCBPCA EOC*.
N/A	OB/GYN and reproductive services language added.
N/A	Physician and provider selection procedures added.
N/A	Referral procedures added.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Acupuncture Services	**Acupuncture Services**
Acupuncture services for the following conditions: • Pain therapy • Nausea that is related to surgery, pregnancy or chemotherapy Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: • Doctor of medicine • Doctor of osteopathy • Chiropractor • Acupuncturist	Benefits include services that are medically necessary services and rendered by a network provider. The services must be for 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. Acupuncture services must be performed by a network provider who has entered into a contract through an arrangement with the plan and who is qualified and duly licensed or certified by the State of California.
Language not included.	**Cellular and Gene Therapy** • Cellular therapy and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office. • Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.
Dental Services – Accident Only	**Dental Services and Oral Surgery - Accident Only**
Criteria is listed within the form in brackets: [Dental services when all of the following are true:...]	**Language and criteria listed without bracketing:** **Dental services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered when all of the following are true.**
Dental Anesthesia Services	**Dental Anesthesia Services**
Language location difference: Services including general anesthesia and associated hospital or alternate facility charges when the clinical status or underlying medical condition of the covered person requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or alternate facility setting. Services are limited to covered persons who are one of the following: • A child under 7 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. • Services for the diagnosis or treatment of a dental disease are not covered health services.	**Anesthesia and associated facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when: (a) the member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting; and (b) one of the following criteria is met:** • The member is under 7 years of age. • The member is developmentally disabled, regardless of age. • The member's health is compromised and general anesthesia is medically necessary, regardless of age. • Also refer to *Section 2: Exclusions and Limitations, B. Dental* for this covered benefit.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Diabetes Services	**Diabetes Services**
Personalized Support - Diabetes Program Enhanced [1]*Network* benefits for certain covered health services may be available to eligible covered persons who are enrolled in the *Personalized Support - Diabetes Program*. Your participation in the *Personalized Support - Diabetes Program* is completely voluntary. You may access any participation requirements and enhanced [1]*Network* benefits for this program through the internet at **myuhc.com** or by calling *Customer Care* at the telephone number on your ID card.	***Personalized Support – Diabetes Program* not included.** **Accounted for in separate language:** Diabetes treatment. Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a physician.
Diabetes Treatment **Language bracketing and location difference:** [Benefits for diabetes prescription items (limited to insulin, medication for the treatment of diabetes, and glucagon) are described in the *Outpatient Prescription Drug Rider.*]	***Diabetes Treatment*** Benefits for diabetes prescription items (limited to insulin, medication for the treatment of diabetes, and glucagon) are described in the *Outpatient Prescription Drug Rider,* if applicable.
Diabetes Treatment **Language location difference and bracketing differences:** Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.	***Diabetic Self-Management Items*** Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. [1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.* Insulin pumps that are not fully implanted into the body and supplies for the management and treatment of diabetes, based upon your medical needs include: • Insulin pumps and all related necessary supplies are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies.* • Blood glucose meters including continuous glucose monitors. • Blood glucose monitors designed to assist the visually impaired. • Insulin syringes with needles. • Blood glucose and urine test strips. • Ketone test strips and tablets. • Lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Durable Medical Equipment	**Durable Medical Equipment (DME), Orthotics and Supplies**
	Benefits are provided for DME and certain orthotics and supplies. If more than one item is clinically appropriate to meet your functional needs, but one is less expensive, benefits are available only for the less expensive item.
Language differences: **Examples of DME include:** • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME and are a covered health service. Braces that straighten or change the shape of a body part are orthotic devices. Dental braces are also excluded from coverage.	**Examples of DME and supplies include:** • Enteral feeding pumps and supplies.
Language included in *Prosthetic Devices section*: Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.	**Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.**
Bracketing exists: [Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to a health condition. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required 3-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]	**No bracketing:** Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to a health condition. Benefits for the purchase of these devices are available only after completing a required 3-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Durable Medical Equipment, continued	**Durable Medical Equipment (DME), Orthotics and Supplies, continued**
Language for orthotics is contained within different sections, i.e.: *Section 2: Exclusions and Limitations, C. Devices, Appliances and Prosthetics* Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.	**Language on orthotic braces and custom foot orthotics is listed under this covered services section:** Benefits for custom foot orthotic devices required to support or correct a defective body part needed as a result of foot disfigurement caused by diabetes.
Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. We will decide if the equipment should be purchased or rented. Benefits are available for repairs and replacement, except that: • Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect. • Benefits are not available to replace lost or stolen items.	**Section includes benefits not covered.** Benefits do not include: • Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a covered health care service for which benefits are available under the applicable medical/surgical covered health care service categories in this *Combined Evidence of Coverage and Disclosure Form*. • Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a covered health care service. • Powered exoskeleton devices. We will decide if the equipment should be purchased or rented. Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.
Emergency Health Services – Outpatient	**Emergency Health Care Services – Outpatient**
Services that are required to stabilize or initiate treatment in an emergency. Emergency health services must be received on an outpatient basis at a hospital or alternate facility. Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a hospital for an inpatient stay). **Language bracketing differences:** [*Include if plan design includes retrospective review of emergency services.*] [Benefits under this section are not available for services to treat a condition that does not meet the definition of an emergency.]	Services that are required to stabilize or begin treatment in an emergency. Emergency health care services to treat emergency medical conditions must be received on an outpatient basis at a hospital or alternate facility. Benefits include the facility charge, supplies and all professional services required to stabilize or eliminate the medical or psychiatric condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a hospital for an inpatient stay). Benefits are not available for services to treat a condition that does not meet the definition of an emergency medical condition. Covered urgently needed medical conditions are described under *Urgent Care Services*.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Gender Dysphoria	**Gender Dysphoria**
Benefits for the treatment of gender dysphoria include the following services: Surgery for the treatment of gender dysphoria, including the surgeries listed below. *Male to Female:* • Clitoroplasty (creation of clitoris) • Labiaplasty (creation of labia) • Orchiectomy (removal of testicles) • Penectomy (removal of penis) • Urethroplasty (reconstruction of female urethra) • Vaginoplasty (creation of vagina) *Female to Male:* • Bilateral mastectomy or breast reduction • Hysterectomy (removal of uterus) • Metoidioplasty (creation of penis, using clitoris) • Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prosthesis • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina) • Vulvectomy (removal of vulva) Genital surgery and bilateral mastectomy or breast reduction surgery documentation requirements.	Benefits for the treatment of gender dysphoria provided by or under the direction of a physician. For the purpose of this benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Gender dysphoria criteria and service details not listed.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Habilitative Services and Manipulative Treatment	**Habilitative Services and Manipulative Treatment**
Language and bracketing difference: **[[1]Habilitative Services Located Under: Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]** Benefits for habilitative services will be covered under the same terms and conditions applied to rehabilitative services under the policy. Habilitative services include the outpatient rehabilitation services listed above. Benefits are provided for habilitative services provided for covered persons when the following condition is met: • The initial or continued treatment must not be an unproven service or experimental or investigational. This condition does not apply to medically necessary occupational therapy or speech therapy for a covered person with a diagnosis of pervasive developmental disorder or autism spectrum disorder. For purposes of this benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Benefits for DME and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies*.]	For purposes of this benefit, "habilitative services" means skilled care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. We will decide if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. **Habilitative services are limited to:** • Physical therapy • Occupational therapy • Manipulative treatment • Speech therapy • Post-cochlear implant aural therapy • Cognitive therapy **Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:** **Treatment is administered by any of the following:** • Licensed speech-language pathologist. • Licensed audiologist. • Licensed occupational therapist. • Licensed physical therapist. • Physician. • Treatment must be proven and not experimental or investigational.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Habilitative Services and Manipulative Treatment, continued	**Habilitative Services and Manipulative Treatment, continued**
Language not included.	**The following are not habilitative services:** • Custodial care • Respite care • Day care • Therapeutic recreation • Vocational training • Residential treatment • A service that does not help you meet functional goals in a treatment plan within a prescribed time frame • Services solely educational in nature • Educational services otherwise paid under state or federal law **This exclusion does not apply to medically necessary services to treat severe mental illness (SMI) or serious emotional disturbances of a child (SED).** **We may require the following be provided:** • Treatment plan • Medical records • Clinical notes Habilitative services provided in your home by a home health agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a home health agency are provided as described under this section. Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Home Health Care	**Home Health Care**
Language differences: Services received from a home health agency that are both of the following: • Ordered by a physician. • Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse. Benefits are available only when the home health agency services are provided on a part-time, intermittent care schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a physician. • It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not custodial care. Benefits will be available after our review of both the skilled nature of the service and the need for physician-directed medical management. A service will not be "skilled" simply because there is not an available caregiver.	**A member is eligible to receive home health care visits if the member:** • Is confined to the home (home is wherever the member makes his or her home but does not include acute care, rehabilitation or skilled nursing facilities); • Needs medically necessary skilled nursing visits or needs physical, speech or occupational therapy; and • The home health care visits are provided under a plan of care established and periodically reviewed and ordered by a UnitedHealthcare network provider. "Skilled nursing services" means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse. **If a member is eligible for home health care visits in agreement with the authorized treatment plan, the following medically necessary home health care visits may be included, but are not limited to:** • Skilled nursing visits. • Home health aide services visits that provide supportive care in the home which are reasonable and necessary to the member's illness or injury. • Physical, occupational, or speech therapy that is provided on a per visit basis. • Medical supplies, DME.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Home Health Care, continued	**Home Health Care, continued**
Language differences, continued	• Infusion therapy medications and supplies and laboratory services as prescribed by a network provider to the extent such services would be covered by UnitedHealthcare had the member remained in the hospital, rehabilitation or skilled nursing facility. • Drugs, medications and related pharmaceutical services are covered for those members enrolled in UnitedHealthcare's outpatient prescription benefit. Outpatient prescription drugs are available as a supplemental benefit. Please refer to your *Schedule of Benefits*. If the member's network medical group determines that skilled nursing service needs are more extensive than the services described in this benefit, the member will be transferred to a skilled nursing facility to obtain services. UnitedHealthcare, in consultation with the member's network medical group, will determine the appropriate setting for delivery of the member's skilled nursing services. Please refer to the *Schedule of Benefits* for any applicable copayments/deductibles and benefit limitations.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Hospice Care	**Hospice Care**
Language differences: Hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the covered person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency. Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.	Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided as determined by the plan of care developed by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's primary care physician, a registered nurse, a social worker and a spiritual caregiver. Hospice services are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver. Hospice services include: • Skilled nursing services. • Certified home health aide services and homemaker services under the supervision of a qualified registered nurse. • Bereavement services. • Social services/counseling services. • Medical direction. • Volunteer services. • Pharmaceuticals, medical equipment and supplies that are reasonable and needed for the palliation and management of the terminal illness and related conditions. • Physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.
Reference to inpatient hospice is not referenced in the UHIC COC. Respite care is referenced in the *Exclusions and Limitations section*, but allows for respite care as part of an integrated hospice care program.	Inpatient hospice services are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or when it is needed to relieve the family members or other persons caring for the member (respite care). Respite care is limited to an occasional basis and to no more than 5 consecutive days at a time.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Infertility Services	**Infertility Services**
Language not included.	Includes: "Benefits include medically necessary standard fertility preservation services when a necessary medical treatment may directly or indirectly cause latrogenic infertility."

Criteria language differences:
To be eligible for benefits, you must meet all of the following:
• The presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or
• 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.
• You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.
	To be eligible for diagnoses, tests, treatment and surgery, you must meet the following:
	• The presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or the inability to conceive a pregnancy.
	• The Inability to conceive a pregnancy or to carry a pregnancy after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
	  • 1 year, if you are a female under age 35.
	  • 6 months, if you are a female age 35 or older.
	• You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

Lab, X-ray and Diagnostics - Outpatient	**Lab, X-ray and Diagnostics - Outpatient**
Include when plan design has an office visit copayment and supports paying the lab/X-ray benefit for services performed in a physician's office. **Differences in language bracketing:** Services health condition-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility [or in a physician's office] include:	Services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office include:
Language differences: **Benefits under this section include:** • The facility charge and the charge for supplies and equipment. • Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other physician services are described under *Physician Fees for Surgical and Medical Services.*)	**Benefits include:** • The facility charge and the charge for supplies and equipment. • Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other physician services are described under *Physician Fees for Surgical and Medical Services.*) • Genetic testing ordered by a physician which results in available medical treatment options following genetic counseling.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Lab, X-ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient **Differences in language heading for major diagnostics.**	**Major Diagnostic and Imaging - Outpatient**
Mental Health Services	**Mental Health Care [and Substance-Related and Addictive Disorders] Services**
Differences in language heading and bracketing for mental health: Benefits for mental health services include covered health services for the diagnosis and treatment of mental illnesses. Mental illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless those services are specifically excluded in *Section 2: Exclusions and Limitations*. Mental health services include those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.	Mental health care and [substance-related and addictive disorders] services include those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office in a group or individual therapy session. Inpatient hospitalizations cover room and board. All services must be provided by or under the direction of a properly qualified behavioral health provider. Benefits under this section include the diagnosis and all medically necessary treatment of SMI of a member of any age and SED of an enrolled dependent child under the same terms and conditions that apply to medical conditions as required by California law. This includes, but is not limited to, copayments and any deductibles.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Mental Health Services, continued	**Mental Health Care [and Substance-Related and Addictive Disorders] Services, continued**

Benefits include the following levels of care:
• Inpatient treatment
• Residential treatment
• Partial hospitalization/day treatment
• Intensive outpatient treatment
• Outpatient treatment
Services include the following:
• Diagnostic evaluations, assessment and treatment planning
• Treatment and/or procedures
• Medication management and other associated treatments
• Individual, family, and group therapy
• Provider-based case management services
• Crisis intervention
• Prescription drugs
	Mental health care benefits include the following levels of care:
	• Inpatient treatment
	• Residential treatment
	• Partial hospitalization/day treatment
	• Intensive outpatient treatment
	• Outpatient treatment
	• Emergency health care services
	Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with 2 or more beds).
	Services include the following:
	• Diagnostic evaluations, assessment and treatment planning.
	• Treatment and/or procedures.
	• Medication management, monitoring of drug therapy and other associated treatments.
	• Psychiatric observation for an acute psychiatric crisis.
	• Individual, family, and group therapy.
	• Provider-based case management services.
	• Crisis intervention.
	• **Services at a residential treatment facility.**
	• **Behavioral health treatment for pervasive development disorders (“PDD”) or autism under the same terms and conditions that apply to medical conditions. Medically necessary behavioral health treatment will not be denied or unreasonably delayed:**
	  • Based on an asserted need for cognitive or intelligence quotient (IQ) testing.
	  • On the grounds that the behavioral health treatment is an experimental or investigational services or educational; or
	  • On the grounds that behavioral health treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Mental Health Services, continued	**Mental Health Care [and Substance-Related and Addictive Disorders] Services, continued**
Language location differences: **Language is located in the *Section 9: Defined Terms* under:** **Behavioral Health Treatment –** *Qualified autism service provider* *Qualified autism service paraprofessional* *Qualified autism service professional*	**Includes added language defining:** *Qualified autism service provider* *Qualified autism service paraprofessional* *Qualified autism service professional*
Language location and bracketing differences: Substance use disorder services	**Mental Health Care [and Substance-Related and Addictive Disorders] Services** [Substance-related and addictive disorders] services.
Obesity - Weight Loss Surgery	**Obesity - Weight Loss Surgery**
Language and bracketing differences: [Surgical treatment of obesity when provided by or under the direction of a physician [when the covered person has a body mass index (BMI) greater than 40].] [Surgical treatment of obesity when provided by or under the direction of a physician when either of the following criteria is met: • [The covered person must have a body mass index (BMI) of greater than 40.] • [The covered person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity].]	"Services are covered when medically necessary and prior authorized. We will use evidence-based criteria to determine coverage of obesity—weight loss surgery, such as the most recent National Institutes of Health (NIH) guidelines, in determining the medical necessity of requests for surgical treatment for morbid obesity. Please refer to your *Schedule of Benefits* for copayment/deductible information of this benefit or you may call the number on your ID card for additional information."
Ostomy Supplies	**Ostomy Supplies**
Bracketing differences: [Benefits for ostomy supplies are limited to the following: • Pouches, face plates and belts • Irrigation sleeves, bags and ostomy irrigation catheters • Skin barriers Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]	Benefits for ostomy supplies are limited to the following: • Pouches, face plates and belts • Irrigation sleeves, bags and ostomy irrigation catheters • Skin barriers Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Prosthetic Devices	**Prosthetic Devices**
Language placement differences: **Benefits are available for repairs and replacement, except that:** • There are no benefits for repairs due to misuse, malicious damage or gross neglect. • There are no benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.	**Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Devices, Appliances and Prosthetics*.** Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items. The exclusion does not apply to services provided under DME, special footwear and the orthotic benefit.
Reconstructive Procedures	**Reconstructive Procedures**
CDI made changes to clarify procedures and moved away from "normal appearance."	**Standard DMHC language that relies on medical necessity and standards in CA we have been using in alignment with HMO.**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	**Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**
Coverage criteria difference for cognitive rehab therapy: Benefits for cognitive rehabilitation therapy only when medically necessary following a post-traumatic brain injury or cerebral vascular accident.	• We will pay for cognitive rehabilitation therapy limited to neuropsychological testing by a provider acting within the scope of his or her license or as authorized under California law and the medically necessary treatment of functional deficits due to a traumatic brain injury or cerebral vascular insult or when provided as part of an authorized autism behavioral health treatment plan.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	**Skilled Nursing Facility/Inpatient Rehabilitation Facility Service**
Language differences: Please note that benefits are available only if both of the following are true: • If the initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost effective alternative to an inpatient stay in a hospital. • You will receive skilled care services that are not primarily custodial care. **Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:** • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a physician. • It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. Benefits will be available after our review of both the skilled nature of the service and the need for physician-directed medical management. A service will not be "skilled" simply because there is not an available caregiver.	Skilled nursing will be provided as medically necessary based upon limits provided in the *Schedule of Benefits*. If a member does not require acute hospital care but intensive skilled nursing is determined to be medically necessary. Subacute and transitional care are levels of care provided by a skilled nursing facility to a member who does not require hospital acute care, but who requires more intensive licensed skilled nursing facility care than is provided to the majority of the patients in a skilled nursing facility. Skilled nursing facility services will be provided in place of a hospital stay when medically necessary, and when prior authorized by the member's network medical group or by UnitedHealthcare. We will determine if benefits are available by reviewing the skilled nature of the service and the need for physician-directed medical management. A benefit period begins on the date the enrollee is admitted to a hospital or a skilled nursing facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior 3-day stay in an acute care hospital is not required to commence a benefit period.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Temporomandibular Joint Services	**Temporomandibular Joint (TMJ) Services**
Language differences: **Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.** Diagnosis: examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment including clinical examinations, physical therapy, pharmacological therapy, oral appliances (orthotic splints), joint injections and trigger-point injections. **Benefits are provided for surgical treatment if the following criteria are met:** • There is clearly demonstrated radiographic evidence of significant joint abnormality, and the procedure being considered for reimbursement is medically necessary. • Non-surgical treatment has failed to adequately resolve the symptoms. • Pain or dysfunction is moderate or severe. Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.	**Services are covered for any medically necessary surgical procedure for any condition directly affecting the upper/lower jawbone or associated bone joints.** Diagnosis: exam, radiographs and applicable imaging studies and consultation. Non-surgical treatment including: • Clinical exams • Oral appliances (orthotic splints) • Arthrocentesis • Trigger-point injections **Benefits are provided for surgical treatment if the following criteria are met:** • There is radiographic evidence of joint abnormality. • Non-surgical treatment has not resolved the symptoms. • Pain or dysfunction is moderate or severe. Benefits for surgical services include: • Arthrocentesis • Arthroscopy • Arthroplasty • Arthrotomy • Open or closed reduction of dislocations Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Transplantation Services	**Transplantation Services**
Language differences: **Organ and tissue transplants when ordered by a physician. Benefits are available for transplants when the transplant meets the definition of a covered health service, and is not an experimental or investigational or unproven service.** Transplant-related exclusions are located in the *Exclusions section* under *Transplants*.	**Organ and tissue transplants including CAR-T cell therapy when ordered by a physician. Benefits are available for transplants when the transplant meets the definition of a covered health care service, and is not an experimental or investigational service.** **Expanded language on covered services and prior authorized/designated provider:** Non-experimental/non-investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a member and the bone marrow or stem cell services are performed at a designated provider. The testing of relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors taking place through a registry are covered when the member is the intended recipient. All organ transplants must be prior authorized by UnitedHealthcare and performed in a designated provider. Transportation and other non-clinical expenses of the living donor are excluded.
Urinary Catheters	**Urinary Catheters**
CDI allowed bracketing/exclusion of urinary catheters.	**DMHC does not allow variability and requires coverage. This is in alignment with forthcoming UHC standards.**

Section 1: Covered Health Care Services

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Virtual Visits	**Virtual Visits**
Language differences: Virtual visits is distinct from telehealth services since there are no restrictions on where virtual visit services can originate. Virtual visits covers audio visual visits with a physician from a designated network and are accessible from any location not limited to home or office or *CMS* originating site. Unlike telehealth services, it requires audio visual medium to facilitate face-to-face interaction for an appropriate evaluation and diagnosis. Virtual visits for covered health services that include the diagnosis and treatment of low acuity medical conditions for covered persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).	Virtual visits for covered health care services that include the diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant physician or health specialist, through use of live audio and video technology outside of a medical facility (for example, from home or from work).
Additional Benefits Required By California Law	**Other Benefits**
Breast Cancer Services	**Listed in *Preventive Care Services section***
Nicotine Use Benefit	**Listed in *Preventive Care Services section* under *Tobacco Screening***
Orthotic Benefit	**Listed in *Durable Medical Equipment (DME), Orthotics and Supplies***
Prosthetic Devices – Laryngectomy	**Listed in *Prosthetic Devices***

Section 2: Exclusions and Limitations

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Devices, Appliances and Prosthetics	**Devices, Appliances and Prosthetics**
Cranial banding.	**Cranial molding helmets and cranial banding except when used to avoid the need for surgery and/or to facilitate a successful surgical outcome.**
Drugs	**Drugs**
Lists the exclusions for drugs and prescriptions items 1–11.	**Directs members to refer to the *Exclusions and Limitations* under *Prescription Drug Products Covered by Your Benefit of your Outpatient Prescription Drug Schedule of Benefits*.**
Experimental or Investigational or Unproven Services	**Experimental or Investigational or Unproven Services**
Experimental or investigational and unproven services and all services related to experimental or investigational and unproven services are excluded except benefits provided for clinical trials for cancer and for experimental or investigational services and unproven services as defined under *Section 9: Defined Terms* and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or life-threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is recommended by 2 clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.	Experimental or investigational services and all services related to experimental or investigational and unproven services are excluded. The fact that an experimental or investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational in the treatment of that particular condition. This exclusion does not apply to covered health care services provided during a clinical trial for which benefits are provided as described under clinical trials in *Section 1: Covered Health Care Services* and *Off-Label Drug Use and Experimental and Investigational Service* in *Section 1: Covered Health Care Services*.
Category Not listed	**Gender Dysphoria**
N/A	**Lists cosmetic services that are excluded for the treatment of gender dysphoria.**
Medical Supplies and Equipment	**Medical Supplies and Equipment**
Allows for the exclusion of: urinary catheters and ostomy supplies.	**Cannot exclude urinary catheters and ostomy supplies.**

Section 2: Exclusions and Limitations

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Physical Appearance	**Physical Appearance**
Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).	**Not listed.**
Treatment for skin wrinkles or any treatment to improve the appearance of the skin.	**Not listed.**
Treatment for spider veins.	**Treatment for spider veins except if medically necessary.**
Hair removal or replacement by any means.	**Not listed.**
Not listed.	Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure; however, medically necessary services related to complications for a non-covered cosmetic procedure are covered. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures in Section 1: Covered Health Care Services*.

Section 2: Exclusions and Limitations

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Procedures and Treatments	Procedures and Treatments
Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Surgical and non-surgical treatment of obesity. Non-surgical treatment of obesity. Surgical treatment of obesity for open vertical banded gastroplasty and laparoscopic vertical banded gastroplasty. Obesity surgery that is not received at a designated facility. Infertility services that are not received at a designated facility. In vitro fertilization which is not provided as an assisted reproductive technology for the treatment of infertility. In vitro fertilization regardless of the reason for treatment. Ventricular assist device implantation that is not performed at a designated facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to emergency implantations of partial assist devices. Congenital heart disease surgery that is not performed at a designated facility.	**These services not listed.**
Not listed.	**Helicobacter pylori *(H. pylori)* serologic testing except medically necessary consistent with professional practice.**
Reproduction	**Reproduction**
Not listed.	**This exclusion does not apply to medically necessary standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility.**
Types of Care	**Types of Care**
Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.	**Not listed.**

Section 2: Exclusions and Limitations

UHIC 2017 LG COC	UHCBP 2019 LG EOC
All Other Exclusions	**All Other Exclusions**
Details not listed.	**Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms.** Medically necessary. Described as a covered health care service in this *Combined Evidence of Coverage and Disclosure Form* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*. Not otherwise excluded in this evidence of coverage under *Section 2: Exclusions and Limitations*. As otherwise required to be covered under the law.

Section 3 intentionally omitted from this comparison brochure.

Section 4: When Coverage Ends

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Language not included.	**Continuity of Care**
	Extensive language on continuity of care.
	Appealing a Termination
	If you believe that we terminated your membership improperly, you may file a grievance to appeal the decision. Please refer to *Section 6: Questions, Complaints and Appeals*. You may also request the Department of Managed Health Care to review your termination.

Section 5: How to File a Claim

UHIC 2017 LG COC	UHCBP 2019 LG EOC
	Assignment of Benefits
Language not included.	You may not assign your benefits under the agreement or any cause of action related to your benefits under the agreement to an out-of-network provider without our consent.

Section 6: Questions, Complaints and Appeals

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Appeal Process	**Appeal Process**
Silent on process.	**Allows for appeal requests to be initiated verbally through customer care.**
Independent External Review Program	**Independent Medical Review**
CDI's external review program.	**Extended language on medical review procedures through the DMHC's process.**

Section 7 intentionally omitted from this comparison brochure.

Section 8: General Legal Provisions

UHIC 2017 LG COC	UHCBP 2019 LG EOC
N/A	Liability of subscriber for payment.
	AB 72 statement on covered services in a network facility received from a non-network provider.
N/A	Subrogation and reimbursement.
	Extended language on the subrogation procedures required under *CVC Sec. 3040*.
Examination of Covered Persons	Do We Require Examination of Covered Persons?
In the event of a question or dispute regarding your right to benefits, we may require that a network physician of our choice examine you at our expense. **Physical examinations and autopsy:** We, at our own expense, shall have the right and opportunity to examine the covered person when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.	In the event of a question or dispute regarding your right to benefits, we may require that a network physician of our choice examine you at our expense.
	Public Policy Participation
Language not included.	UnitedHealthcare Benefits Plan of California gives its members the opportunity to participate in establishing its public policy. At least 51% of the members of UnitedHealthcare Benefits Plan of California's Public Policy Committee are subscribers/members. If you are interested in participating in the establishment of UnitedHealthcare Benefits Plan of California's public policy, please call the number on your ID card.

Schedule of Benefits Changes

UHIC 2017 LG COC	UHCBP 2019 LG EOC
Acupuncture Services	**Acupuncture Services**
Out-of-network benefits options included: 20%–50% Coinsurance or $5–$10 per visit.	**Market mandate excludes OON coverage:** **Out-of-network benefits are not available.**
Home Health Care	**Home Health Care**
Out-of-network benefits included: 5%–50% coinsurance or $5–$50 per visit or After you pay $5–$50 per visit you will pay none or 5%–50% of the remaining allowed amount.	**Market mandate places OON coverage cap at $150 per visit:** For out-of-network benefits, allowed amounts are limited to $150 per visit. Certain covered health care services apply an allowed amount as shown below. **Allowed amounts section will clarify OON cap amounts:** • Home health care services, for which benefits are provided as described under home health care in the certificate: up to $150 per visit.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	**Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**
Out-of-network benefits included: None; 5%–50%; $5–$150 per visit; or out-of-network benefits are not available.	**Market mandate excludes OON coverage for physical therapy, occupational therapy, and manipulative treatment.** 5%–50% for all therapies, except for physical therapy, occupational therapy, and manipulative treatment. Physical therapy, occupational therapy, and manipulative treatment: Out-of-network benefits are not available.
Surgery - Outpatient	**Surgery - Outpatient**
Out-of-network benefits included: None; 5%–50%; $5–$1,500 per date of service; $5–$1,500 per date of service, to a maximum of $5–$5,000 per year; or After you pay $5–$1,000 per date of service you will pay none; 5%–50% of the remaining allowed amount.	**Market mandate places OON coverage cap at $760 per date of visit:** For out-of-network benefits, allowed amounts for facility fees are limited to $760 per date of service. Certain covered health care services apply an allowed amount as shown below. **Allowed amounts section will clarify OON cap amounts:** • Facility fees for services provided as described under surgery - outpatient in the certificate: up to $760 per date of service.

New Prescription Drug List for ACA-Compliant Certificate of Coverage

51+ HMO groups renewing July 1, 2019, and after will be moved from the Signature Value formulary to a UnitedHealthcare Prescription Drug List (PDL). Pharmacy benefits and services will remain the same:

- Access to network of over 67,000 retail pharmacies.
- Home delivery with OptumRx—prescriptions and refills.
- Digital experience—Find a Pharmacy, Refill My Prescriptions, Order History, and other digital experiences do not change. Members do not need to re-register on myuhc.com or the app.
- Consumer Call Center—one call support for medical and pharmacy questions and 24/7 pharmacist support.
- Group- and member-level issue resolution process
- Specialty pharmacy, with injectable medications continued to be covered under the medical benefit.

New and expanded member engagement programs:

Automated Transition of Care program automatically allows members up to 2 grace fills (each grace fill is up to a 31 day supply at retail) for a previously prescribed medication or medications that have clinical review requirements.

PreCheck MyScript is a streamlined tool that gives providers real-time access into a specific member's pricing, lower-cost alternative medication options, and PDL placement.

Preferred90 program gives members the option to fill their 90-day supplies of maintenance medications. Member can choose either home delivery through OptumRx or to fill at any CVS Pharmacy location for the same 90-day supply member cost share.

Benefits NOT Changed—Product Standards are generally the same for 2019 ACA-Compliant COC

- Ambulance
- Clinical trials
- Congenital heart disease surgeries
- Hospital—inpatient stay
- Pharmaceutical products—outpatient
- Physician fees for surgical and medical services
- Physician's office services—sickness & injury
- Pregnancy—maternity services
- Preventive care services
- Reconstructive procedures
- Rehabilitation services—outpatient therapy and manipulative treatment
- Scopic procedures—outpatient
- Skilled nursing facility**
- Surgery—outpatient
- Therapeutic treatments—outpatient
- Urgent care
- Virtual visits

UnitedHealthcare®

**Visit or day limits may change for EHB groups.

Health plan coverage provided by or through UnitedHealthcare Insurance Company, UHC of California and UnitedHealthcare Benefits Plan of California. Administrative services provided by United Healthcare Services, Inc., OptumRx or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

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