

# UnitedHealthcare of Texas, Inc.

## Written Plan Description

### Health Maintenance Organization Plans (TX HMO Plans)

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This coverage is provided by UnitedHealthcare of Texas, Inc., a Health Maintenance Organization health care plan. This coverage provides benefits only when a Preferred Provider (Network Provider) is used, except as otherwise noted.

If you have questions or need additional information, you may contact us at:

[1311 W. President George Bush Highway  
Richardson, TX 75080  
1-800-458-5653  
[www.myuhc.com]]

[1250 Capital of Texas Highway South  
Building 1, Suite 400  
Austin, Texas 78746  
1-800-424-6480  
1-800-842-0174  
[www.myuhc.com]]

[2000 West Loop South, Suite 900  
Houston, Texas 77027  
1-800-548-1078  
[www.myuhc.com]]

### Benefits for Covered Health Services

After enrolling, you will receive an Evidence of Coverage (EOC) which contains specific information regarding your health care benefits. Refer to the EOC to understand exact coverage for certain conditions, services, and supplies. All services and supplies must be Medically Necessary as defined in the EOC.

- **Acquired Brain Injury** - Benefits are provided for services as a result of and related to an acquired brain injury. Benefits include cognitive communication therapy; cognitive and neurocognitive rehabilitation therapy; community reintegration services; neurofeedback therapy; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment; post-acute transition services; and remediation.
- **Ambulance Services** - Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Services can be performed is covered. Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) between facilities is available from a non-Network Hospital to the closest Network Hospital; to the closest Network Hospital to provide services that were not available at the original Hospital; or from a short-term acute care facility to the closest Network long-term acute care facility, Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.
- **Amino Acid-Based Elemental Formulas** - Benefits are provided, regardless of the formula delivery method, for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; severe food protein-induced enterocolitis syndrome; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.
- **Autism Spectrum Disorder Services** - Benefits are provided for an Enrolled Dependent child who has been diagnosed with an Autism Spectrum Disorder. Benefits include screening for Autism

Spectrum Disorders, evaluation and assessment services, physical, occupational, and speech therapy, medications and nutritional supplements.

- **Clinical Trials** - Routine patient care costs incurred during participation in a qualifying phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition are covered.
- **Diabetes Services** - Benefits include diabetes equipment, diabetes supplies and diabetes self-management training programs.
- **Durable Medical Equipment** - Benefits are provided for equipment that is ordered or provided by a Physician for outpatient use, used for medical purposes, and not consumable or disposable.
- **Emergency Health Services** - Benefits are available for services that are required to stabilize or initiate treatment in an Emergency.
- **Gender Dysphoria** - Benefits include treatment provided by or under the direction of a Physician.
- **Hearing Aids/Cochlear Implants** - Benefits are available for the correction of a hearing impairment. Benefits include the associated fitting, testing and dispensing services; habilitation and rehabilitation as necessary for educational gain; and an external speech processor and controller for cochlear implants.
- **Home Health Care** - Benefits include skilled nursing by a registered nurse or licensed vocational nurse; physical, occupational, speech or respiratory therapy; the service of a home health aide, under the supervision of a registered nurse; and medical equipment and medical supplies other than drugs and medicines.
- **Hospice Care** - 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.
- **Hospital-Inpatient Stay** - Benefits are available for supplies and non-physician services; room and board in a semi-private room; meals and special diets; general nursing care; private duty nursing; x-ray services; labs; drugs, medications, biologicals, anesthesia and oxygen services; radiation therapy; inhalation therapy; whole blood and the administration; and short term rehabilitation services.
- **Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings** - Benefits include screenings for human papillomavirus, cervical cancer and ovarian cancer.
- **Lab, X-Ray, Diagnostics, Major Diagnostics, CT, PET, MRI, MRA and Nuclear Medicine** - Services for diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility includes lab and radiology/X-ray; mammography; non-invasive screening tests for atherosclerosis and abnormal artery structure such as ultrasonography measuring carotid intima-media thickening and plaque. Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility, including coverage for noninvasive screening tests for atherosclerosis and abnormal artery structure such as computed tomography (CT) scanning measuring coronary artery calcification are covered.
- **Mental Health Services and Serious Mental Health Services** - Benefits include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.
- **Neurobiological Disorders** - Benefits include behavioral services for Autism Spectrum Disorders.
- **Orthotic Devices and Prosthetic Devices** - Benefits are available for only the most appropriate model of prosthetic (artificial device designed to replace, an arm or leg) or orthotic device (a custom-fitted or custom-fabricated medical device applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease) that meets your needs.
- **Osteoporosis Detection and Prevention** - Benefits are available for medically accepted bone mass measurements for the detection of low bone mass.
- **Pharmaceutical Products** - Benefits include Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Benefits are provided only for Pharmaceutical Products which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional.
- **Phenylketonuria (PKU) and Other Heritable Diseases** - Benefits are provided for formulas necessary to treat phenylketonuria or a heritable disease.

- **Physician Fees for Surgical and Medical Services** - Benefits include medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, via telemedicine or telehealth, or for Physician house calls.
- **Physician's Office Services** - Benefits are available for services provided by a Physician in the office for the diagnosis and treatment of a Sickness or Injury.
- **Pregnancy-Maternity Services** - Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.
- **Prescription Drug Benefits** - Benefits include Prescription Drugs medications that are typically available by prescription order or refill at a pharmacy. You may visit [www.uhc.com/employer/pharmacy](http://www.uhc.com/employer/pharmacy) for formulary information.
- **Preventive Care Services** - Benefits are available for medical services on an outpatient basis that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, and have been proven to have a beneficial effect on health outcomes.
- **Reconstructive Procedures** - Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function are covered. Benefits include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly.
- **Rehabilitation - Outpatient Therapy** - Rehabilitation services that are performed by a Physician or by a licensed therapy provider are covered.
- **Scopic Procedures** - Benefits are available for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.
- **Skilled Nursing Facility / Inpatient Rehabilitation Facility Services** - Benefits are available for supplies and non-Physician services, room and board, and Physician services for skilled care (skilled nursing, skilled teaching and skilled rehabilitation services).
- **Speech and Hearing Services** - Services required as treatment for the loss or impairment of speech or hearing. Benefits include developmental, educational and learning speech and hearing therapy.
- **Substance Use Disorder Services and Chemical Dependency Services** - Benefits are provided for services to treat Substance Use Disorder and Chemical Dependency. Benefits include detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being.
- **Surgery** - Benefits include the facility charge and the charge for supplies and equipment for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.
- **Temporomandibular Joint Services (TMJ)** - Benefits are provided for services for the evaluation and treatment of TMJ and associated muscles, including the jaw and the craniomandibular joint, which are required as a result of an accident, trauma, congenital defect, developmental defect or pathology.
- **Therapeutic Treatments** - Treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology are covered.
- **Transplantation Services** - Benefits are available for organ and tissue transplants when ordered by a Physician and when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.
- **Urgent Care Center Services** - Benefits include services received at an Urgent Care Center.
- **Virtual Visits** - Virtual visits 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).

## Emergency, After Hours or Urgent Medical Services

### Emergency Services

“Emergency Care” means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical

conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate medical care could result in: placing the individual's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of a bodily organ or part; serious disfigurement; or for a pregnant woman, serious jeopardy to the health of the fetus.

In an emergency, call 911 or go to the nearest emergency room. Benefits are available for network or out-of-network providers when emergency care is received.

### **After Hours Care**

For care after hours, first call your participating physician. Participating physicians provide either an answering service or detailed answering message that gives instructions for accessing care after hours. You may also call UnitedHealthcare at the telephone number on the back of your ID card. Registered nurses are available 24 hours a day, seven days a week for health care guidance to assist you.

### **Urgent Care Services**

Urgent care health services are covered when provided by a Network Physician or provider when immediate treatment of a medical condition is necessary. Urgent care centers provide medical care with less wait time and at a much lower cost than an emergency department of a local hospital.

### **Out- of-Area Services**

UnitedHealthcare arranges for Participating Network physicians and providers within your service area. With the exception of Emergency Services or other specific services authorized by your Network physician or UnitedHealthcare, when you are out of your geographic area, you are not covered for any other medical or hospital services.

### **Required Disclosure: Health Benefit Plan**

All facility-based physicians or other health care practitioners at contracted health care facilities may not be contracted with UnitedHealthcare of Texas, Inc.

In these situations, the out-of-Network facility-based physician or other health care practitioner may balance bill you for amounts not paid by your health plan.

If you receive a balance bill, you should contact UnitedHealthcare of Texas, Inc. at [[www.myuhc.com](http://www.myuhc.com)] or the telephone number on your ID card.

### **Financial Responsibility**

The Covered Person is responsible for payment of the required premium as well as the deductible, cost share percentage, copayment amounts and any other out-of-pocket expenses for non-covered services. The copayment and any other cost share percentage or deductible amount is determined by your plan. You may access these amounts by reviewing your Evidence of Coverage (EOC). Consumer Choice plans do not include all state mandated health insurance benefits. Therefore, these plans may include deductibles and benefit limits that are not included on other plans.

Network physicians and providers have agreed to look only to the HMO and not to its members for payment of Covered Health Services. For Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

### **Exclusions**

Not all services are covered under your plan. The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the EOC or through a Rider. The following is a summary of services that are not covered.

- **Alternative Treatments** - Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
- **Dental** - Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition. Endodontics, periodontal surgery and restorative treatment. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Dental implants, bone grafts and other implant-related procedures. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.
- **Devices, Appliances and Prosthetics** - Cranial banding; blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech. Oral appliances for snoring. Repairs or replacement of prosthetic devices due to misuse, malicious damage or gross neglect.
- **Experimental, Investigational or Unproven Services** - Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven 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 or Unproven in the treatment of that particular condition.
- **Foot Care** - Routine foot care; hygienic and preventive maintenance foot care; treatment of flat feet; treatment of subluxation of the foot; shoes; or shoe orthotics, inserts and arch supports.
- **Gender Dysphoria** - Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.
- **Medical Supplies** - Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters.
- **Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders** - Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.
- **Nutrition** - Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy.
- **Personal Care, Comfort or Convenience** - Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort.

- Pharmacy** - Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds or is less than the minimum the supply limit. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay. Benefits for these drugs are provided in your Evidence of Coverage (under the medical portion of the plan). Experimental, Investigational or Unproven Services and medications. Prescription Drug Products furnished by the local, state or federal government. Prescription Drug Products for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Evidence of Coverage. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered. Unit dose packaging or repackagers of Prescription Drug Products. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition). A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Prescription Drug Products when used for sleep aids. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy. A Prescription Drug Product that contains marijuana, including medical marijuana. Dental products, including but not limited to prescription fluoride topicals. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product (for the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision).
- Physical Appearance** - Cosmetic Procedures. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs. Weight loss programs. Wigs regardless of the reason for the hair loss.
- Procedures and Treatments** - Excision or elimination of hanging skin on any part of the body. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 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. Biofeedback, unless the service is rendered with the diagnosis of acquired brain injury. Surgical and non-surgical treatment of obesity. Stand-alone multidisciplinary smoking cessation programs. Breast reduction surgery except as required by the *Women's Health and Cancer Rights Act of 1998*.
- Providers** - Services performed by a provider who is a family member by birth or marriage. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists. Services performed by a provider with your same legal residence. Services provided at a

Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic or Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received.

- **Reproduction** - Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. The reversal of voluntary sterilization. Fetal reduction surgery.
- **Services Provided under Another Plan** - Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance contract. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.
- **Transplants** - Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the EOC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility.
- **Travel** - Health services provided in a foreign country, unless required as Emergency Health Services.
- **Types of Care** - Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing, except when services are received on an Inpatient basis. Respite care. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
- **Vision and Hearing** - Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Routine vision examinations, including refractive examinations to determine the need for vision correction.
- **Other Exclusions**- Health services and supplies that do not meet the definition of a Covered Health Service, including services, supplies, or Pharmaceutical Products. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Contract when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Contract ends. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Contract. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, Cost Share Percentage, any deductible or other amount owed for a particular health service, no Benefits are provided. Charges in excess of Eligible Expenses or in excess of any specified limitation. Foreign language and sign language services.

## Pre-authorization of Services

We require pre-authorization of services before you receive certain Covered Health Services. You, your Primary Care Physician or other Network provider are responsible for submitting a request for pre-authorization before the services are received.

To obtain pre-authorization, call the telephone number on your ID card. This call starts the utilization review process. The utilization review process is a set of formal techniques which may include non-emergent

ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

If pre-authorization is not obtained for Covered Health Services, the amount you are required to pay will be increased to 50% of the Allowed Amount, not exceeding \$500.

### **Continuation of Care**

If you are undergoing a course of treatment from a Network provider at the time that Network provider is no longer contracted with us, you may be entitled to continue that care covered at the Network benefit level.

Continuity of care is available in special circumstances in which the treating Physician or health care provider reasonably believes discontinuing care by the treating Physician could cause harm to the Covered Person. Special circumstances include Covered Persons with a disability acute condition, life-threatening illness or past the 24th week of Pregnancy.

The continuity of care request must be submitted by the treating Physician or provider. If continuity of care is approved, it may not be continued beyond 90 days after the Physician or provider is no longer contracted with us, if the Covered Person has been diagnosed as having a terminal illness at the time of the termination, or the expiration of the nine month period after the effective date of the termination. If the Covered Person is past the 24th week of Pregnancy at the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six week period after delivery.

### **Questions, Complaints or Appeals**

If you have a question, complaint or appeal, call the telephone number shown on your ID card. If we are unable to resolve your question or complaint over the phone, you will need to submit a written request to the address at the beginning of this summary. We will notify you of the outcome within 30 days of receiving all the information related to your request.

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision or adverse determination. We will assemble a complaint appeal panel to resolve your appeal. We will complete the appeals process not later than the 30th calendar day after we receive your written appeal. Our final decision on the appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

You also have the right to appeal your Adverse Determination through an Independent Review Organization (IRO). We will notify you when this option is available during your appeal process.

Any person, including persons who have attempted to resolve complaint and appeals through our complaint system process and who are dissatisfied with the resolution, may file a complaint with the *Texas Department of Insurance* at P.O. Box 149091, Austin, Texas 78714-9091. The *Department's* telephone number is 1-800-252-3439.

Refer to the EOC for a complete explanation of your complaint and appeal rights.

We shall not engage in any retaliatory action against any Group or Covered Person because the Group or Covered Person has filed a complaint against UnitedHealthcare of Texas, Inc, or appealed a decision. We shall not retaliate for any reason against a physician or provider because the physician or provider has, on behalf of the Covered Person, reasonably filed a complaint against UnitedHealthcare of Texas, Inc. or appealed a decision.

### **Network Providers**



A Network provider is a hospital, physician or other health care provider who is contracted with us for the purpose of reducing health care costs by negotiating fees for services provided to Covered Persons. An out-of-Network provider is a hospital, physician or other health care provider who is not contracted with us.

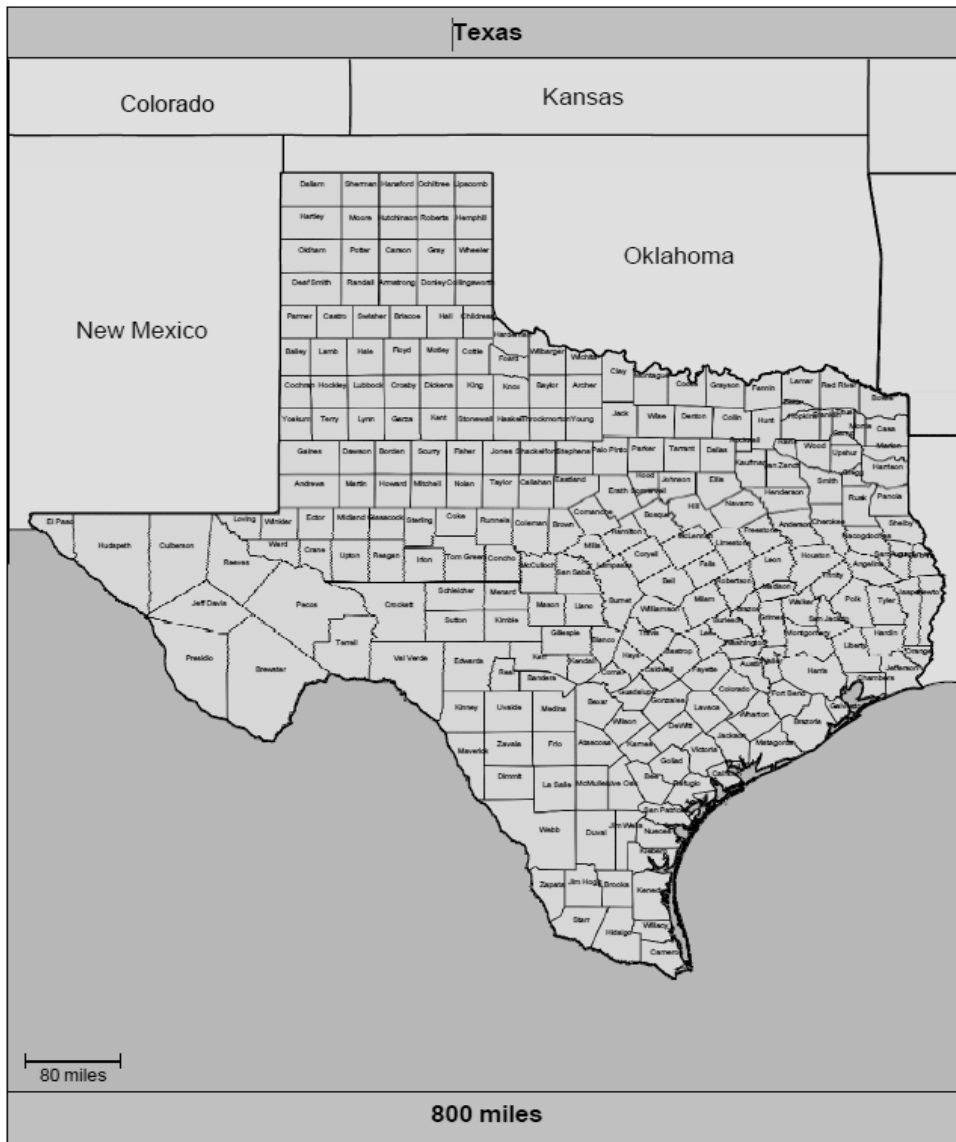
A list of Network providers can be obtained by visiting the UnitedHealthcare provider lookup website at [[www.uhc.com/find-a-physician](http://www.uhc.com/find-a-physician)]. This website will provide you with information regarding the location and availability of providers within the HMO network. If you would like a printed copy of the provider directory, contact us at the address or telephone number at the beginning of this summary, we will send it free of charge upon request.

## Notice of Rights

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Evidence of Coverage and below.
- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: [www.tdi.texas.gov/consumer/complfrm.html](http://www.tdi.texas.gov/consumer/complfrm.html).
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network co-payment, cost share percentage, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: [[www.uhc.com/find-a-physician](http://www.uhc.com/find-a-physician)] or by calling [1-855-828-7715] for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

## Service Area

Network providers may be found throughout your Service Area. The map below shows that the Service Area includes all counties within the state of Texas. A list of Network providers within your Service Area can be obtained by contacting us at the address or telephone number at the beginning of this summary or you may visit the UnitedHealthcare provider lookup website at [www.uhcwest.com](http://www.uhcwest.com). If you would like a printed copy of providers, we will send it free of charge upon request.



## Choosing Your Physician

After choosing UnitedHealthcare of Texas, Inc., you will then need to decide who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP is also part of a 'network' or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB- GYN) that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

**ATTENTION FEMALE ENROLLEES:** You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP.