CALIFORNIA

Provided by ACN Group of California, Inc. d/b/a OptumHealth Physical Health of California

Chiropractic Health Benefits Plan

Supplement to the 2026 Combined Evidence Of Coverage (EOC) and Disclosure Form

NOTICE OF NONDISCRIMINATION

ACN Group of California, Inc. d/b/a OptumHealth Physical Health of California (Optum) complies with civil rights laws and does not discriminate against, exclude, or treat individuals unfairly on the basis of race, color, national origin, ancestry, religion, marital status, age, disability, sex (including pregnancy, sexual orientation, gender, and gender identity).

This statement is in compliance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued according to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number 1-800-428-6337. (TTY 711.)

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, marital status, age, disability, or sex (including pregnancy, sexual orientation, gender, and gender identity), you can send a complaint to the Optum Civil Rights Coordinator:

Optum Civil Rights Coordinator
1 Optum Circle
Eden Prairie, MN 55344
Optum_Civil_Rights@Optum.com

If you need help filing a complaint, call the toll-free number 1- 800-428-6337. (TTY 711).

United States Department of Health and Human Services – Office of Civil Rights
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you need more help, call the Department of Managed Health Care (DMHC) at 1-888-466-2219. If you need help filing a grievance, please call toll-free 800-428-6337, TTY 711, Monday through Friday, 8:30 am - 5 pm PT.

This notice is available at: myoptumhealthphysicalhealthofca.com

English

IMPORTANT LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. If you need more help, call DMHC Help Center at 1-888-466-2219.

Español (Spanish)

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA:

Usted podría tener los derechos y servicios que se indican a continuación. Puede obtener los servicios de un intérprete o de traducción sin cargo. En algunos idiomas, la información escrita también podría estar disponible sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud: ACN Group of California, Inc. 1-800-428-6337 /TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la DMHC Help Center al 1-888-466-2219.

繁體中文 (Traditional Chinese)

重要語言資訊：

您可能有權享有以下權利和服務。您可以免費取得口譯或翻譯服務。書面資訊也可能免費提供某些語言版本。如欲以您的語言取得協助，請致電您的健保計劃：ACN Group of California, Inc. 1-800-428-6337 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 DMHC Help Center 協助專線 1-888-466-2219。

اللغة العربية (Arabic)

معلومات مهمة عن اللغة:

قد تكون مؤهلًا للحقوق والخدمات أدناه. يمكنكَ الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. ربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. للحصول على المساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: ACN Group of California, Inc. بولاية على الرقم 711 :TTY/ 1-800-1-800-428-6337. إذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بمركز المساعدة التابع لمنظمة صون الصحة (DMHC Help Center) على الرقم 1-888-466-2219.

Հայերէն (Armenian)

ԿԱՐԵՎՈՐ ՏԵՂԵՔԱՏՎՈՒԹՅՈՒՆ ԼԵԶՎԻ ՎԵՐԱԲԵՐՅԱԼ

Դուք կարող եք օգտվել ստորև նշված իրավունքներից և ծառայություններից: Դուք կարող եք անվճար օգտվել թարգմանչի ծառայություններից: Գրավոր տեղեկատվությունը կարող է նաև անվճար հասանելի լինել որոշ լեզուներով: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական պլան հետևյալ համարով՝ ACN Group of California, Inc. 1-800-428-6337 / TTY. 711. Հավելյալ օգնության կարիքի դեպքում, զանգահարեք DMHC Help Center-ի Օգնության գիծ՝ 1-888-466-2219 h

ខ្មែរ (Khmer)

ព័ត៌មានសំខាន់អំពីភាសា៖

អ្នកអាចនឹងមានសិទ្ធិទទួលបានសិទ្ធិនិងសេវាកម្មខាងក្រោម។ អ្នកអាចទទួលបានសេវាអ្នកបកប្រែផ្តាល់មាត់ ឬសេវាបកប្រែឯកសារដោយឥតគិតថ្លៃ។ ព័ត៌មានជាសំណេរក៏អា

ចរកបានជាភាសាមួយចំនួនដោយឥតគិតថ្លៃដងដែរ។ ដើម្បីទទួលបានជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅគម្រោងសុខភាពរបស់អ្នកតាមលេខ៖ គម្រោង ACN Group of California, Inc. 1-800-428-6337 / TTY: 711។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែម សូមទូរសព្ទទៅខ្សែទូរសព្ទជំនួយរបស់ DMHC Help Center តាមលេខ 1-888-466-2219។

فارسی (Farsi)

اطلاعات مهم زبانی:

ممکن است حق استفاده از حقوق و خدمات زیر را داشته باشید. شما می‌توانید مترجم یا خدمات ترجمه بدون هزینه دریافت کنید. همچنین ممکن است اطلاعات مکتوب به برخی زبان‌ها بدون پرداخت هزینه در دسترس باشد. برای دریافت کمک به زبان خود، لطفاً با طرح سلامت خود در این آدرس تماس بگیرید: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط تلفنی کمک و راهنمایی DMHC Help Center به شماره 1-888-466-2219 تماس بگیرید.

हिंदी (Hindi)

महत्वपूर्ण भाषा सूचना:

आप निम्नलिखित अधिकारों और सेवाओं के लिए पात्र हो सकते हैं। आप मुफ्त में दूभाषिया या अनुवाद सेवाओं का लाभ उठा सकते हैं। लिखित जानकारी शायद कुछ भाषाओं में मुफ्त में उपलब्ध हो सकती है। अपनी भाषा में सहायता के लिए, कृपया अपनी स्वास्थ्य योजना से संपर्क करें: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. अगर आपको और सहायता की जरूरत है, तो DMHC Help Center हेल्प लाइन 1-888-466-2219 पर कॉल करें।

Hmoob (Hmong)

TEJ NTAUB NTAWV HAIS TXOG HOM LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai raws li cov cai thiab cov kev saib xyuas hauv qab no.Yuav pab kws txhais lus rau koj los sis txhais ntawv rau koj pub dawb.Tej zaum kuj cov ntaub ntawv sau ua qee hom pub dawb rau koj thiab.Yuav tau txais kev pab txhais ua koj hom lus, ces thov hu rau koj qhov kev npaj kho mob rau ntawm: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711.Yog koj xav tau kev pab ntxiv, hu rau DMHC Help Center Tus Xov Tooj Pab ntawm 1-888-466-2219.

日本語 (Japanese)

言語についての重要な情報：

お客様は、次のような権利およびサービスを受ける資格をお持ちかもしれません。お客様は、通訳または翻訳サービスを無料でご利用いただけます。書面による情報も、いくつかの言語にて無料でご利用いただける場合があります。日本語での支援をご希望の方は、ご利用の医療保険プランにお電話ください：ACN Group of California, Inc. 1-800-428-6337 / TTY：711。さらに支援が必要な場合は、DMHC Help Center ヘルプライン（1-888-466-2219）にお電話
ください。

한국어 (Korean)

중요한 언어 정보:

귀하는 다음의 권리와 서비스를 받을 자격이 있을 수 있습니다. 귀하는 무료로 통역사 또는 번역 서비스를 받을 수 있습니다. 서면 정보 또한 일부 언어들로 무료로 이용할 수 있습니다. 귀하의 언어로 도움을 받으시려면, 다음으로 귀하의 건강보험에 전화하십시오. ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. 더 많은 도움이 필요하신 경우, DMHC Help Center 헬프라인에
1-888-466-2219 번으로 전화하십시오.

ਪੰਜਾਬੀ (Punjabi)

ਭਾਸ਼ਾ ਸੰਬੰਧੀ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਦੁਭਾਸ਼ੀਏ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਵੀ ਉਪਲਬਧ ਹੋ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ DMHC Help Center ਹੈਲਪ ਲਾਈਨ ਨੂੰ 1-888-466-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Русский (Russian)

ВАЖНАЯ ИНФОРМАЦИЯ О ЯЗЫКОВЫХ УСЛУГАХ:

Вы можете получить перечисленные ниже права и услуги. Вы можете бесплатно воспользоваться услугами устного или письменного переводчика. Письменная информация также может быть бесплатно предоставлена на нескольких языках. Чтобы получить помощь на Вашем языке, позвоните в свой план медицинского страхования: ACN Group of California, Inc., Калифорния 1-800-428-6337 / линия TTY: 711. За дополнительной помощью Вы можете обращаться в справочную службу DMHC Help Center по телефону 1-888-466-2219.

Tagalog (Tagalog)

MAHALAGANG IMPORMASYON SA WIKA:

Maaari kang maging karapat-dapat sa mga karapatan at serbisyo sa ibaba. Maaari kang makakuha ng mga serbisyo ng interpreter o pagsasalin sa wika nang walang bayad. Ang nakasulat na impormasyon ay maaari ring maging available sa ilang wika nang walang bayad. Para makakuha ng tulong sa iyong wika, pakitawagan ang iyong health plan sa: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Kung kailangan mo ng karagdagang tulong, tumawag sa Linya ng Tulong ng DMHC Help Center sa 1-888-466-2219.

ไทย (Thai)

ข้อมูลภาษาที่สำคัญ:

คุณอาจได้รับสิทธิ์และบริการดังนี้ คุณสามารถขอรับบริการล่ามหรือการแปลได้โดยไม่มีค่าใช้จ่าย ข้อมูลที่เป็นลายลักษณ์อักษรอาจมีให้ในบางภาษาโดยไม่มีค่าใช้จ่าย

หากต้องการความช่วยเหลือในภาษาของคุณ โปรดติดต่อแผนประกันสุขภาพของคุณที่: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. หากคุณต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือของ DMHC Help Center ที่หมายเลข 1-888-466-2219

Tiếng Việt (Vietnamese)
THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:
Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu một thông dịch viên hoặc dịch vụ phiên dịch miễn phí. Thông tin dạng văn bản cũng có thể được cung cấp miễn phí ở một số ngôn ngữ. Để được trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Nếu quý vị cần thêm trợ giúp, vui lòng gọi Đường dây trợ giúp DMHC Help Center theo số 1-888-466-2219.

Language Assistance Services

You may be entitled to the following rights and services under California law which shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services.

Interpretation services and translated written materials are available to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. Appropriate auxiliary aids and services are also available to the member, including qualified interpreters for individuals with disabilities and information in alternate formats, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. These services will be provided free of charge in a timely manner upon request. To get help in your language, please call your health plan, ACN Group of California at: **800-428-6337/TTY: 711**, Monday through Friday, 8:30 a.m. to 5:00 p.m. pacific time (PT). If you need more help, call the Department of Managed Health Care (DMHC) Help Line at 1-888-466-2219.

This information is available in other formats like large print. To ask for another format, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8:30 a.m. to 5 p.m.

THIS IS A SUPPLEMENT TO THE SUTTER HEALTH PLAN MEDICAL COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CHIROPRACTIC HEALTH BENEFITS PLAN

Your Sutter Health Plan Medical Plan includes Chiropractic coverage through ACN Group of California, Inc. d/b/a OptumHealth Physical Health of California ("ACNCA"). This "*Supplement to the Combined Evidence of Coverage and Disclosure Form*" (*EOC*) discloses the terms and conditions of coverage. You have the right to review this *EOC* prior to enrollment. If you have special health care needs, review this *EOC* completely and carefully to determine if this benefit provides coverage for your special needs.

ACN Group of California, Inc., d/b/a OptumHealth Physical Health of California, Inc.
P.O. Box 880009
San Diego, CA 92168-0009
Phone: 1-800-428-6337
1-888-877-5379 (voice), or 1-888-877-5378 (TDD)

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ATTACHMENTS

INTRODUCTION

This document describes the terms under which ACN Group of California, Inc. *d/b/a OptumHealth Physical Health of California* (ACN) will provide a chiropractic benefits program to employees of the **Employer Group** and their Family Dependents who have enrolled under the Group Subscriber Contract between Sutter Health Plan and the **Employer Group**.

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

SECTION 1. DEFINITIONS

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

1.1 Annual Benefit Maximum

"Annual Benefit Maximum" means an amount specified in the *Schedule of Benefits* which is the maximum amount that ACN is obligated to pay on behalf of a Member for Covered Services of a particular type or category provided to a Member in a given calendar year benefit/ or calendar year, as indicated in your Schedule of Benefits.

1.2 Chiropractic Disorder

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

1.3 Chiropractic Services

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

1.4 Chiropractor

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

1.5 Claims Determination Period

"Claims Determination Period" means a calendar year or that part of the calendar year during which a person is covered by this Plan.

1.6 Coverage Decision

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

1.7 Department

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

1.8 Disputed Health Care Service

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

1.9 Exclusion

"Exclusion" means any service, equipment, supply, accommodation or other item specifically listed or described as excluded in the Group Subscriber Contract or this *EOC*.

1.10 Family Dependent

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

1.11 Limitation

"Limitation" means any provision, other than an Exclusion, contained in the Group Subscriber Contract, this *EOC* or the attached *Schedule of Benefits*, which limit the covered Chiropractic Services to which Members are entitled.

1.12 Neuromusculoskeletal Disorders

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

1.13 Participating Provider

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

1.14 *Schedule of Benefits*

"*Schedule of Benefits*" means the summary of Copayments, Annual Benefit Maximums, Exclusions and Limitations applicable to Member's chiropractic benefits program. The *Schedule of Benefits* is Attachment A to this *EOC*.

1.15 Telehealth

"Telehealth" is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes real-time interactions and the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient. The originating site and the distant site are licensed to provide Telehealth according to applicable law.

1.16 Urgent Services

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

SECTION 2. PRINCIPAL BENEFITS AND COVERAGES

Members are entitled to receive the Covered Services described in this Section when such services are Medically Necessary for the treatment of a Member's Chiropractic Disorder, subject to all applicable Exclusions and Limitations and Benefit Maximums, as well as all other terms and conditions contained in this EOC and the Group Subscriber Contract.

2.1 Chiropractic Services Description

Chiropractic Services provided include:

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

(B) Initial patient examinations;

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

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

(E) Examination of any aspect of the Member's condition by means of radiological (x-ray) diagnostic imaging or clinical laboratory tests, if performed by an ACN participating Chiropractor;

(F) Spinal and Extraspinal Treatment; and

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

2.2 Urgent Services

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

2.3 Emergency Services

If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment. Members are encouraged to use appropriately the 911 emergency response system, in areas where the system is established and operating, when they have an emergency condition that requires an emergency response. Covered Services which are considered Emergency Services are available and accessible within the service area twenty-hours a day, seven days a week.

2.4 Second Opinions

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

2.4.1 Second Opinion Requests

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

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* **Durable Medical Equipment or DME** means equipment that can withstand repeated use by Members outside a provider's office or facility, is primarily or customarily used in the treatment of Chiropractic Disorders, and is generally not useful to a Member in the absence of a Chiropractic Disorder. Members should refer to the Schedule of Benefits at Attachment A for a description of the DME covered under the benefit plan, and Section 3.2 for a description of the Limitations applicable to DME.

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

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

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

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

Members may request a second opinion by contacting ACN's Customer Services Department at the toll-free telephone number listed on the front page of this *EOC*.

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

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

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

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

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

2.4.2 **Plan Review of Requests for Second Opinions**

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

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

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

A copy of ACN's Policy and Procedure regarding second opinions is available to Members and the public upon request. Members may request a copy of the Policy and Procedure by contacting ACN's Customer Services Department at the toll-free telephone number listed on the front page of this *EOC*.

2.5 Continuity of Care

Upon a Member's request, ACN will consider for the completion of Covered Services for an "acute condition," a "serious chronic condition," "Pregnancy," "terminal illness," or care of a newborn child between birth and age 36 months when (1) a newly enrolled Member, at the time the Member becomes eligible for coverage, is already receiving services from a Non-Contracting Provider prior to enrollment, or (2) a currently enrolled Member is receiving Covered Services from a Provider whose contract terminates, provided the Member was receiving care from that Provider before the termination. Members who wish to request continuity of care coverage or a copy of ACN's Policy and Procedure regarding continuity of care should contact ACN's Customer Services Department at the toll-free telephone number listed on the front page of this *EOC*, or by writing to the Customer Services Department at the following address:

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

Members may also fax their questions or requests to ACN at (619) 641-7185.

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

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

Except as otherwise provided by applicable law:

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

2.5.2 In cases involving an acute condition, ACN shall furnish the Member with Covered Services for the duration of the acute condition.

2.5.3 In cases involving a serious chronic condition, ACN shall furnish the Member with Covered Services for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Participating Provider as determined by ACN in consultation with the terminated provider, consistent with good professional practice. Completion of Covered Services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

2.5.4 In cases involving terminal illness, Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

2.5.5 In cases involving pregnancy, completion of Covered Services shall be provided for the duration of the pregnancy.

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

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

2.5.8 **Definitions.** For purposes of this Section 2.5, the following definitions will apply:

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

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

2.5.8.3 "Provider" is Chiropractor duly licensed under California law to deliver or furnish Chiropractic Services.

2.5.8.4 "Participating Provider" has the same meaning as stated in Section 1.13 of this *EOC*.

2.5.8.5 "Non-Contracting Provider" is a Provider who is not party to a contract with the Plan to provide Chiropractic Services.

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

2.5.9 Terminated Providers. In the event the criteria listed in the continuity of care section 2.5 are met; ACN will require a Terminated Provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that applied to the provider prior to termination, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Terminated Provider does not agree to comply or does not comply with these contractual terms and conditions, ACN will not continue the Terminated Provider's services beyond the contract termination date. In such cases, ACN will refer the Member to a Participating Provider.

Unless otherwise agreed by the Terminated Provider and ACN, the services rendered shall be compensated at rates and methods of payment similar to those used by ACN for Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Terminated Provider. ACN will not continue the services of a Terminated Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 2.5.9. In such cases, ACN will refer the Member to a Participating Provider.

2.5.10 Non-Contracting Providers. In the event the criteria listed in the continuity of care section (2.5) are met; ACN will allow a Non-Contracted Provider to treat a Member, as long as the provider agrees in writing to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as the Non-Contracting Provider, including, but not limited to, credentialing, utilization review, peer review, and quality assurance requirements. If the Non-Contracting Provider does not agree to comply or does not comply with these contractual terms and conditions, ACN will not continue the provider's services. In such cases, ACN will refer the Member to a Participating Provider.

Unless otherwise agreed upon by the Non-Contracting Provider and ACN, the services rendered shall be compensated at rates and methods of payment similar to those used by ACN for Participating Providers providing similar services who are practicing in the same or a similar geographic area as the Non-Contracting Provider. ACN will not continue the services of a Non-Contracted Provider if the provider does not accept the payment rates and methods of payment provided for in this Section 2.5.10. In such cases, ACN will refer the Member to a Participating Provider.

2.5.11 Limitations. Members are not eligible to keep their provider if the provider does not agree to be subject to the same contractual terms and conditions that apply to Participating Providers providing similar services and who are practicing in the same or a similar geographic area as your provider. Members are not eligible to keep their provider if their provider had a contract with ACN which was terminated or not renewed for reasons relating to a medical disciplinary cause or reason, fraud, or other criminal activity. New Members

are not eligible to keep their provider if the Member had the option to continue with another ACN or provider and voluntarily chose to change ACNs. In each of these cases, ACN will refer the Member to a Participating Provider. ACN will not cover services that are not otherwise covered under a Member's benefit plan.

2.5.12 If a Member is not satisfied with ACN's decision, a Member may file a grievance with ACN subject to the terms and instructions included in Section 6 of this *EOC*.

2.6 Facilities

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

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

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

2.7 Telehealth Services

Benefits are available for Covered Services received through Telehealth. No in-person contact is required between a Participating Provider and a Member for Covered Services appropriately provided through Telehealth, subject to all terms and conditions of the Group Subscriber Contract.

Prior to the delivery of Covered Services via Telehealth, the health care provider at the originating site shall verbally inform the Covered Person that Telehealth may be used and obtain verbal consent from the Member for this use. The verbal consent shall be documented in the Member's medical record.

ACN shall not require the use of Telehealth services when the Participating Provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Participating Provider pursuant to his or her contract with us.

Covered Services that are the same, as determined by the Participating Provider's description of the Covered Service on the claim, shall be reimbursed at the same rate whether provided in-person or through Telehealth. For services provided via Telehealth, Copayment shall not be greater than the same Copayment if the Covered Service were provided in-person.

Coverage for health care services appropriately delivered through telehealth services are covered on the same basis and to the same extent that the plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

SECTION 3. PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

3.1 Exclusions

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

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

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

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

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

(E) Experimental or investigative services unless required by an external, independent review panel as described in Section 6.5;

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

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

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

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

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

(K) Transportation to and from a provider;

(L) Drugs or medicines;

(M) Intravenous injections or solutions;

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

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

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

(Q) Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, and treatment for an educational requirement;

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

(S) Ambulance services;

(T) Surgical services;

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

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

3.2 Limitations

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

SECTION 4. CHOICE OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS CHIROPRACTIC CARE MAY BE OBTAINED.

4.1 Access to Participating Provider

Each Member who requests that Covered Services be provided will be able to choose from any ACN Participating Provider who will coordinate the Covered Services to be received by the Member. Members may request access to a Participating Provider by going to www.myoptumhealthphysicalhealthofca.com or by contacting ACN's Customer Services Department at the toll-free telephone number printed on the front page of this *EOC*.

4.2 Liability of Member for Payment

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

4.3 Relationship with and Compensation to Participating Providers

ACN itself is not a Provider of Acupuncture and/or Chiropractic Health Services. ACN typically contracts with independent Providers to provide Acupuncture and/or Chiropractic Services to its Members. Once they are contracted, they become ACN Participating Providers. ACN's network of Participating Providers may include individual practitioners, group practices, and facilities. None of the Participating Providers or their employees are employees or agents of ACN. Likewise, neither ACN nor any employee of ACN is an employee or agent of any Participating Provider. Participating Providers are paid on a discounted fee-for-service basis for the services they provide. They have agreed to provide services to you at the normal fee they charge, minus a discount. ACN does not compensate nor does it provide any financial bonuses or any other incentives to its internal staff and/or Participating Providers based on their utilization patterns. If you would like to know more about fee-for-service reimbursement, you may request additional information from ACN's Customer Service department or your Participating Provider.

SECTION 5. MANAGED CARE PROGRAM

5.1 Managed Care Program

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

5.2 Managed Care Process

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

5.3 Appeal Rights

All decisions made by ACN in connection with the Managed Care Program may be appealed by the Member through the Grievance Procedure set forth in Section 6.

5.4 Utilization Management

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

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

5.4.2 **Benefit Coverage Determinations.** Benefit coverage determinations are made by ACN's Support Clinicians based upon your benefit plan and may include an adverse determination due to a Limitation in benefit coverage or an Exclusion of benefit coverage. These are not medical necessity determinations.

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

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

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

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

5.4.5.2 An Authorization Response is sent to the provider and Enrollee indicating the Support Clinician's decision within one day of the date of decision. The written response is sent to the provider by U.S. Mail. Written notification is sent to the Enrollee by U.S. Mail within two (2) business days of the date of the decision.

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

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

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

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

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

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

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

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

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

5.4.7 Nothing in this Section 5 shall be construed or applied to interfere with a Member's right to submit a grievance or seek an independent medical review in accordance with applicable law. Members shall in all cases have an opportunity to submit a grievance to ACN or seek an independent medical review whenever a health care service is denied, modified, or delayed by ACN, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not Medically Necessary.

5.4.8 All grievances shall be handled in accordance with ACN's Grievance Resolution Policies and Procedures, as described in Section 6.

5.4.9 A request for an independent medical review shall be handled in accordance with ACN's policies and procedures on independent medical reviews or, if applicable, the policies and procedures on independent review of decisions regarding experimental or investigational therapies, as described in Section 6.5.

SECTION 6. GRIEVANCE PROCEDURES

6.1 Applicability of the Grievance Procedures

All Member disputes and controversies arising under ACN will be resolved pursuant to the Grievance Procedures set forth in this Section 6.

6.2 Grievances

Every Member has the right to communicate a grievance to ACN by calling the telephone number listed below, by submitting a written grievance to the address indicated below, by submitting a written grievance by facsimile or e-mail, or by completing an online grievance form.

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

You may submit a formal complaint or an appeal for any type of grievance within 180 calendar days of your receipt of an initial determination through our Appeals, Complaints, and Grievances Department. ACN will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of ACN's receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, ACN's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in this *EOC* that exclude that coverage.

ACN will acknowledge receipt of the all routine grievances in writing within five (5) calendar days of receipt. This deadline does not apply to exempt grievances which are grievances that are received by telephone, by facsimile, or by email, that are not coverage disputes, Disputed Health Care Services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day.

If the grievance pertains to a Quality of Service issue, it may be investigated and resolved by ACN. If the grievance pertains to a Quality of Care issue and is routine, ACN transfers the information to the Medical Director. If the grievance pertains to a Quality of Care issue and is urgent, ACN will promptly initiate the Expedited Review process.

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

Grievance forms and ACN's grievance policies and procedures are available to Members upon request.

6.3 Expedited Review of Grievances

For Member grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a Member's health care coverage, or in any other case where the Department determines that an earlier review is warranted, a Member shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting

a grievance to the Department for review. ACN shall immediately inform the Member, in writing, of the Member's right to notify the Department, and to provide the Member and the Department written notice of the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the grievances.

6.4 Independent Medical Review

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

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

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

6.5 IMR for Experimental and Investigational Therapies

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

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

6.6 Implementation of IMR Decision

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

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

6.7 Voluntary Mediation and Binding Arbitration

If you are dissatisfied with ACN's Appeal Process determination, you can request that ACN submit the appeal to voluntary mediation or binding arbitration before JAMS.

Voluntary Mediation
In order to initiate voluntary mediation, either you or the agent acting on your behalf must submit a written request to ACN. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The

Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

Binding Arbitration
All disputes of any kind, including, but not limited to, claims relating to the delivery of services under the plan and claims for medical malpractice between the Member (including any heirs, successors or assigns of Member) and ACN, except for claims subject to ERISA, will be submitted to Binding Arbitration. Medical malpractice includes any issues or allegations that medical services rendered under ACN were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. This means that disputes between the Member and ACN will not be resolved by a lawsuit or by pursuing other court processes and remedies, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Under this provision, neither the Court nor any arbitrator may delay arbitration of disputes or refuse to order disputes to arbitration. The intent of this arbitration provision, and the parties, is to put litigation on hold so that issues can be resolved through the binding arbitration process. Any disputes about the scope of arbitration, about the arbitration itself or about whether an issue falls under this arbitration provision will be resolved by the arbitrator to avoid ambiguities and litigation costs.

The Member and ACN understand and agree that they are giving up their constitutional rights to have disputes decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator. The arbitration will be performed by JAMS or another arbitration service as the parties may agree in writing. The arbitration will be conducted under the JAMS Comprehensive Arbitration Rules and Procedures. The parties will attempt in good faith to agree to the appointment of an arbitrator, but if agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator will be chosen using the appointment procedures set out in the JAMS Comprehensive Arbitration Rules and Procedures. These rules may be viewed by the Member at the JAMS Web site, www.jamsadr.com. If the Member does not have access to the internet, the Member may request a copy of the rules from ACN, and arrangements will be made for the Member to obtain a hard copy of the rules and procedures.

Arbitration hearings will be held in San Diego County, California or at a location agreed to in writing by the Member and ACN. The expenses of JAMS and the arbitrator will be paid in equal shares by the Member and ACN. Each party will be responsible for any expenses related to discovery conducted by them and their own attorney fees. In cases of extreme hardship, ACN may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and JAMS approves the application. The approval or denial of the hardship application will be determined solely by JAMS. The Member will remain responsible for their own attorney fees, unless an award of attorney fees is allowable under the law and the arbitrator makes an award of attorney fees to the Member. Following the arbitration, the arbitrator will prepare a written award that includes the legal and factual reasons for the decision.

Nothing in this Binding Arbitration provision is intended to prevent the Member or ACN from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court. However, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, will be subject to this Binding Arbitration provision. Any claim for permanent injunctive relief will be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, will apply to the arbitration.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED IN COURT BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION

6.8 Department Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your ACN, you should first telephone your ACN at **(1-800-428-6337) or for TDD (1-888-877-5379)** and use your ACN's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your ACN, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an

impartial review of medical decisions made by a ACN related to the medical necessity of a proposed service or treatment, Coverage Decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance.

SECTION 7. GENERAL INFORMATION

7.1 Relationship Between ACN and Each Participating Provider

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

7.2 Overpayments

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

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

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

(C) Which exceeds the amounts to which the Member is entitled under the Group Subscriber Contract.

7.3 Interpretation of Benefits

Subject to the Member grievance procedures specified in Section 6, ACN has the sole and exclusive discretion to do all of the following:

(A) Interpret benefits under the plan.

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

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

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

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

7.4 Administrative Services

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

7.5 Preventive Health Information

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