

Important Notice on Payment of Out-of-Network Benefits

Certain health care plans administered or insured by affiliates of UnitedHealth Group, Incorporated provide “out-of-network” medical and surgical benefits for members. With out-of-network benefits, members may use doctors and other health care professionals outside of the UnitedHealthcare network. The member or professional, depending on whether or not the member has assigned his or her claim, sends a claim for such professional services to be paid to a UnitedHealth Group affiliate. The UnitedHealth Group affiliate will pay based on language in the member’s health plan that in many cases requires the amount to be the lower of either:

- the out-of-network provider’s actual charge billed to the member,
or
- “the reasonable and customary amount,” “the usual, customary, and reasonable amount,” “the prevailing rate,” or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

What Do These Terms Mean?

The terms “the reasonable and customary amount,” “the usual, customary, and reasonable amount,” and “the prevailing rate” are standards that health plans use to pay out-of-network benefits by reference to various available resources. These resources contain information on the charges or costs for professional services or supplies. The resource used for payment of professional services is based on what other health care professionals in the relevant geographic areas or regions charge for their services. The relevant geographic area or region is one or more three-digit zip codes (also called a “geozip” as further described below) covering the place where the health care service was delivered.

These standards do not apply to plans where reimbursement is determined based solely on Medicare rates. Further,

UnitedHealth affiliates use different resources in applying these standards with respect to services provided by facilities such as general hospitals or ambulatory surgical centers or in determining the reimbursement for pharmaceutical products (as further discussed below). Also, a member's health plan may define these standards differently or contain additional standards, and it is the language of the member's health plan or the plan's interpretation of such language that is controlling. A member, therefore, should always consult his or her health plan when assessing how much he or she may be reimbursed for out-of-network benefits.

How Does This Affect Me as a Member?

If your health care plan requires payment using the term "reasonable and customary" or similar language mentioned above with respect to medical and surgical procedures performed and billed by health care professionals or health care provider group practices, affiliates of UnitedHealth Group most commonly refer to a schedule of charges created by Ingenix, Inc., a wholly owned subsidiary of UnitedHealth Group, when determining the maximum amount they will pay for such benefits. Ingenix publishes two databases called the Prevailing Healthcare Charges System database ("PHCS Database") and the Medical Data Research database ("MDR Database"). The information in these databases is updated and published by Ingenix at scheduled times each year. UnitedHealth Group affiliates which administer health care plans based on the term "reasonable and customary" or similar standards use the medical or surgical modules of one of these databases for reimbursement of professional fees for medical and surgical services. By using the schedule of charges in the medical and surgical modules of these databases, the maximum payments a UnitedHealth Group affiliate makes to members will, at times, be less than the amount billed for particular professional services. This then affects the members' "out-of-pocket" cost they must pay to out-of-network health care professionals because the members are

responsible for the difference between the professionals' charges and what the UnitedHealth Group affiliate pays.

How are the Ingenix Schedules Prepared and Used for Payments?

The PHCS Database is designed to use actual, fee-for-service health care professional charges for private sector health care services, or as explained below, when not enough information is available, it reports values based on a methodology using derived charges and relative values. Ingenix collects information from insurers and other health plan administrators nationwide, including information from Puerto Rico and the Virgin Islands. Ingenix asks these contributors to submit only actual fee-for-service charges that professionals have billed. Data contributors receive a discount on their license fees for the PHCS or MDR Databases based on how much of their charges information is accepted and used by Ingenix.

After Ingenix collects billed charge information from data contributors, Ingenix reviews the information before using it to create the PHCS and MDR Databases. Specifically, Ingenix excludes information that (i) is out of date, (ii) is incomplete (missing data fields such as a procedure code, zip code, or billed charge), (iii) contains invalid zip codes or procedure codes, or (iv) has billed amounts that fall outside of certain high and low charge parameters set by Ingenix to identify what it deems to be "outlier" charges.

The PHCS Database sets forth amounts determined by the Ingenix process, organized by medical procedure codes, known as CPT codes, and geographic area (geozips). For CPT code/geozip combinations with 9 or more actual charges used by Ingenix in creating the PHCS product, the Database reports those charges at the 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th "percentiles." By way of example, the 90th percentile is the amount equal to or greater than 90% of the charges used by Ingenix in creating the PHCS Database for that CPT code/geozip combination. Affiliates of UnitedHealth

Group frequently use the 80th percentile of the PHCS Database as their benchmark, but plan sponsors may choose different percentiles for use with their plans. For CPT code/geozip combinations with fewer than 9 actual charges in the repository of data collected from contributors for use in the PHCS Database, the Database reports “derived charges” in the percentile tables. To calculate derived charges, Ingenix pools billed charges for similar services from the relevant geographic area. The charge data is standardized using “relative values,” which are numbers that are assigned to procedure codes based on an assessment of the difficulty and expense of the procedures. More complex and more expensive procedures receive higher relative values, while less complex and less expensive procedures receive lower relative values. For the PHCS Database, Ingenix licenses its relative values from a company not affiliated with UnitedHealth or Ingenix called Relative Value Studies Incorporated (<http://www.rvsdata.com/about.html>).

The MDR Database consists entirely of derived charges. Ingenix uses its own proprietary relative values in creating the MDR Database, and the derived charges methodology used for the MDR Database is different from, though similar to, that used for the PHCS Database.

The medical and surgical modules of the PHCS and MDR Databases currently contain tables covering over 8,000 different codes across over 400 different Geozips. Each release of the Databases uses the data contributed with dates of service during a 12-month moving window between 3 and 15 months prior to the date each module is released.

The service and product codes employed in the Databases are based on either the Current Procedural Terminology (“CPT”) coding system developed and maintained by the American Medical Association (“AMA”) or the Healthcare Common Procedure Coding System (“HCPCS”) developed and maintained by the Centers for Medicare and Medicaid Services (“CMS”). The Databases are divided into “modules,” which

are compilations of the various tables for different codes that are generally related to one another (e.g., there is a PHCS medical services module and a PHCS surgical services module). There are eight different modules for the PHCS Database and nine modules for the MDR Database. UnitedHealth affiliates currently use only the medical and surgical modules of the PHCS Database when they reimburse claims under “reasonable and customary” or other similar standards as described above for professional services delivered and billed by health care professionals or health care provider groups.

Geozips are used to group the charges for a particular CPT code by similar geographical area for summarization and presentation in the database tables. Geozips are based on the first three digits of United States zip codes and can be either a single three-digit zip code area or a combination of two or more three-digit zip code areas. Whether a Geozip covers only one or more than one three-digit zip code area is based upon: (i) an analysis of submitted charge data for each PHCS release; (ii) the volume of available data; and (iii) geographical similarities involved with the zip code areas underlying each Geozip. The zip code areas that are combined in particular Geozips can vary from year-to-year.

A sample PHCS percentile table is provided below.

CPT Code	Description	50th	60th	70 th	75th	80th	85 th	90th	95th
45378	COLONOSCOPY	\$764	\$783	\$859	\$887	\$907	\$939	\$1008	\$1105
71050	RADIOLOGICAL EXAMINATION (2 VIEWS)	\$102	\$103	\$106	\$107	\$107	\$107	\$113	\$122
99211	OFFICE VISIT; EVALUATION AND MANAGEMENT; MINIMAL PRESENTING PROBLEM	\$62	\$70	\$75	\$80	\$85	\$85	\$100	\$100

New Database to Replace Existing System

The Attorney General of the State of New York ("NYAG") initiated an investigation concerning conflicts of interest related to the ownership and use of the PHCS and MDR Databases and the fairness of their rates. Under a January 2009 settlement agreement between UnitedHealth Group and the NYAG, the PHCS and MDR Databases will close and a new, independent database ("New Database") will be established. The New Database will be owned and operated by FAIR Health, Inc., a nonprofit organization selected by the NYAG. Information about FAIR Health is posted on the NYAG's website: www.oag.state.ny.us

After the New Database is operational, FAIR Health will make it available both for research and as a tool for use by health insurance companies to determine out-of-network payment. Until the New Database is available, Ingenix will continue to create and publish the PHCS and MDR Databases, and health plans managed by UnitedHealth Group affiliates will continue to use either of these databases to determine payment for out-of-network professional services when reimbursed under "reasonable and customary" or similar standards as described above.

Important Exclusions

Neither the PHCS nor MDR Databases, nor the New Database, will be used to determine out-of-network medical and surgical benefits for professional services if your health plan does not require payment under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate" or similar terms. For example, if your plan provides for payment solely based upon Medicare rates, your plan is not affected by the agreement between UnitedHealth Group and the NYAG.

Reimbursement Policies

Regardless of whether a UnitedHealth Group affiliate uses the PHCS or MDR Databases to determine the amount it will allow for out-of-network benefits, all affiliates apply certain payment policies that can affect both the amount they pay for such benefits and a member's out-of-pocket costs. For example, the Multiple Procedure Policy applies when multiple procedures are performed on the same day by the same healthcare professional. Under this policy, coverage for the primary/major procedure is 100% of the allowable amount, and 50% of the allowable amount for the secondary procedure. Coverage for all subsequent procedures is 25 or 50% of the allowable amount, depending on your health plan. This accounts for the fact that many medical and surgical services include pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service (like recording preoperative, intraoperative, and postoperative documentation) that would be performed for the primary procedure and not duplicated for additional procedures. For descriptions of the Multiple Procedure Policy and other payment policies, please go to:

<https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=0e22f2ccadd1c010VgnVCM100000c520720a>

Physician Administered Pharmaceuticals

UnitedHealth affiliates consider pharmaceutical products administered and billed by health care professionals or health care provider groups to be professional services or supplies for purposes of claims reimbursement when such drugs are covered under a member's health plan. UnitedHealth Group affiliates generally deem the Average Wholesale Price ("AWP") for such pharmaceutical products to be an amount which satisfies plan standards such as "reasonable and customary" or similar standards mentioned above, and thus use AWP to determine out-of-network reimbursement for such products.

The AWP values considered by UnitedHealth Group affiliates are provided by a comprehensive database covering virtually every drug product approved by the Food and Drug Administration for manufacture and distribution. This database is developed and maintained by an independent vendor, Thomson Reuters, and is collected from over 1,200 pharmaceutical manufacturers and distributors.

UnitedHealth Group affiliates reimburse for pharmaceutical products administered and billed by health care professionals or health care provider groups by reference to AWP for a number of reasons. AWP is an industry standard of reimbursement and is widely accepted by health care professionals, governments, and managed care companies as appropriate payment for such products. In addition, government studies demonstrate that reimbursement at AWP typically is significantly higher than actual prices paid by health care professionals for pharmaceutical products. Finally, the prices paid by health care professionals for these products do not vary across geographic regions to the degree that charges for professional services vary across geographic regions, which makes a national standard on reimbursement for these products more appropriate and more consistent with the plan standards mentioned above.

Glossary

Allowable amount – as used in circumstances covered by this notice, the dollar amount eligible for reimbursement with respect to a claim for out-of-network benefits. The standard for determining the allowed amount can vary by health plan, and may be based (depending upon the language of a member’s health plan) upon the lower of either the provider’s charge or the “reasonable and customary amount,” as explained in the beginning of this notice. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any co-insurance or deductible that is owed by the member.

Provider network – doctors and other health care professionals who agree to provide medical care to our members, under the terms of a contract.

Out-of-network benefits – benefit plan coverage for services or supplies provided by doctors and other health care professionals who are not parties to a contract with a UnitedHealth Group affiliate.

Out-of-pocket cost – portion of the cost of health services that the plan member must pay, including the difference between the amount charged by an out-of-network provider and what a UnitedHealth Group affiliate pays for such services.

Prevailing Healthcare Charges System database (“PHCS Database”) – one of two compilations of information on health care professional charges created by Ingenix, Inc., a wholly owned subsidiary of UnitedHealth Group.

MDR database – one of two compilations of information on health care professional charges created by Ingenix, Inc., a wholly owned subsidiary of UnitedHealth Group.

CPT codes – a set of codes and descriptions of services and procedures performed by physicians and other health care professionals. Each service and procedure is identified by its own five-digit code. Physicians and other health care professionals use CPT codes in making claims for payment. CPT codes are maintained by the American Medical Association.

Ingenix – a wholly-owned subsidiary of UnitedHealth Group (NYSE: UNH).

UnitedHealth Group – UnitedHealth Group (NYSE: UNH) is a diversified health and well-being company dedicated to making health care work better. Headquartered in Minneapolis, Minn., UnitedHealth Group offers a broad spectrum of products and services through six operating businesses: UnitedHealthcare,

Ovations, AmeriChoice, OptumHealth, Ingenix, and Prescription Solutions. Through this family of businesses, UnitedHealth Group affiliates serve more than 70 million individuals nationwide.

The New Database – a new, independent database to be owned, developed and operated by FAIR Health, Inc., a nonprofit organization selected by the New York Attorney General.

Attorney General of the State of New York – Governor Andrew M. Cuomo was the New York State Attorney General at the time of the investigation and settlement agreement. For more information, go to www.oag.state.ny.us