

Information on Payment of Out-of-Network Benefits

Certain health care benefit 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 be entitled to payment for covered expenses if they use doctors and other health care professionals outside of the UnitedHealthcare network. The member or health care professional, depending on whether or not the member has assigned his or her claim, may send a claim for such out-of-network professional services to be paid by a UnitedHealth Group affiliate. The UnitedHealth Group affiliate will pay based on the terms of the member's health care benefit plan that in many cases provides for payment for amounts that are 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 among the standards that various health care benefit plans may use to pay out-of-network benefits. Such plans determine the amounts payable under these standards 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.

These standards do not apply to plans where reimbursement is determined using 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 care benefit plan may define these standards differently or contain additional standards, and it is the language of the member's health care benefit plan or the plan's interpretation of such language that is controlling. Therefore, a member should always consult his or her health care benefit plan when assessing how much he or she may be reimbursed for out-of-network benefits.

How Does This Affect Members?

If a health care benefit 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 professional group practices, then the affiliates of UnitedHealth Group most commonly refer to a schedule of

charges created by FAIR Health, Inc. (“FAIR Health”) to determine the amount of the payment.

What is FAIR Health?

FAIR Health is a not-for-profit company, independent of UnitedHealth Group affiliates, established following the New York Attorney General’s (“NYAG”) investigation into alleged conflicts of interest related to the ownership and use of Ingenix, Inc.’s Prevailing Healthcare Charges System database (“PHCS Database”) and Medical Data Research database (“MDR database”) and the fairness of their rates. Ingenix, Inc. (“Ingenix”), now known as Optum Insight, Inc. (“Optum Insight”), is a wholly-owned subsidiary of UnitedHealth Group Incorporated. Under a January 2009 settlement agreement between UnitedHealth Group Incorporated and the NYAG, Ingenix’s PHCS and MDR Databases closed following the establishment of the new database to be owned and operated by FAIR Health.

FAIR Health provides health care consumers with an estimate of how much out-of-network services will cost them. Health care consumers can access FAIR Health’s Consumer Price Lookup at: <http://fairhealthconsumer.org/>.

Additionally, FAIR Health publishes two Benchmark data products called the FH Benchmark Database and the FH RV Benchmark Database. The information in these FAIR Health Benchmark databases is updated and published by FAIR Health 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/surgical module of one of these FAIR Health Benchmark Databases to determine the maximum amount they will pay for reimbursement of professional fees for medical and surgical services. By using the schedule of charges in the medical/surgical module of these FAIR Health Benchmark databases, the maximum amount a UnitedHealth Group affiliate will pay to members will, at times, be less than the amount billed for particular professional services. Use of this maximum amount then affects the members' "out-of-pocket" cost they must pay to out-of-network health care professionals, under the terms of many health care benefit plans, members are responsible for the difference between the professionals' charges and what the UnitedHealth Group affiliate pays.

How are the FAIR Health Databases Used For Out-of-Network Payments?

Various health insurers and plan administrators periodically send FAIR Health data about claims for services of health care professionals. The claims include the date and the place of the service, the procedure code, and the provider’s charge. FAIR Health combines this information into databases that show how much health care professionals have charged for nearly all services in defined geographic areas in the United States. FAIR Health creates and publishes two Benchmark Databases named the FH Benchmark Database and the FH RV Benchmark Database. Depending on the applicable health care plan, UnitedHealth Group affiliates may use one of these databases as a resource for

determination of reimbursement amounts for out-of-network services of health care professionals.

The following example illustrates the information gathered by FAIR Health in the FH Benchmark Database: FAIR Health receives charge information of health care professionals who perform colonoscopies in a particular geographic area for a particular time period. The charges of these health care professionals for colonoscopies are arranged from low to high and then percentiles are identified from that arrangement. Here is a simplified illustration of a percentile chart for a colonoscopy for one geographic area:

CPT Code	Description	50th	60th	70th	75th	80th	85th	90th	95th
45378	COLONOSCOPY	\$764	\$783	\$859	\$887	\$907	\$939	\$1008	\$1105

Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals, but plan designers and administrators of particular health care benefit plans may choose different percentiles for use with applicable health care benefit plans. Members may contact the customer service line of the applicable UnitedHealth Group affiliate shown on the back of the member’s health identification card to learn of the percentile applicable to the member’s health plan.

Health care benefit plans managed by UnitedHealth Group affiliates began to use FAIR Health’s Benchmarking Databases to determine payment for out-of-network professional services within 60 days of first receiving the applicable FAIR Health Benchmark Database Modules at various times in 2011. Prior to receiving the FAIR Health Benchmarking Database Modules, UnitedHealth Group affiliates used Ingenix’s PHCS database schedules and MDR database schedules to determine payment for out-of-network professional services when reimbursed under standards such as “reasonable and customary” and other similar standards.

For additional information regarding the FAIR Health Benchmark Databases, please visit FAIR Health’s website: www.fairhealthus.org.

How were the Ingenix Schedules Prepared and Used for Payments?

The PHCS Database was 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 was available, it reported values based on a methodology using derived charges and relative values. Ingenix collected information from insurers and other health plan administrators nationwide, including information from Puerto Rico and the Virgin Islands. Ingenix asked these contributors to submit only actual fee-for-service charges that professionals billed. Data contributors received a discount on their license fees for

the PHCS or MDR Databases based on how much of their charges information was accepted and used by Ingenix.

After Ingenix collected billed charge information from data contributors, Ingenix reviewed the information before using it to create the PHCS and MDR Databases. Specifically, Ingenix excluded information that (i) was out of date, (ii) was incomplete (missing data fields such as a procedure code, zip code, or billed charge), (iii) contained invalid zip codes or procedure codes, or (iv) had billed amounts that fell outside of certain high and low charge parameters set by Ingenix to identify what it deemed to be "outlier" charges.

The PHCS Database set 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 reported those charges at the 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th "percentiles." By way of example, the 90th percentile was 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 used the 80th percentile of the PHCS Database as their benchmark, but plan sponsors may have chosen 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 reported "derived charges" in the percentile tables. To calculate derived charges, Ingenix pooled billed charges for similar services from the relevant geographic area. The charge data was standardized using "relative values," which were numbers that were assigned to procedure codes based on an assessment of the difficulty and expense of the procedures. More complex and more expensive procedures received higher relative values, while less complex and less expensive procedures received lower relative values. For the PHCS Database, Ingenix licensed 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 consisted entirely of derived charges. Ingenix used its own proprietary relative values in creating the MDR Database, and the derived charges methodology used for the MDR Database was different from, though similar to, that used for the PHCS Database.

The medical and surgical modules of the PHCS and MDR Databases contained tables covering over 8,000 different codes across over 400 different Geozips. Each release of the Databases used 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 were 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 were divided into "modules," which were compilations of the various tables for different codes that were generally related to one another (e.g., there is a PHCS medical services module and a PHCS surgical services module). There were eight different modules for the PHCS Database and nine modules for the MDR Database. UnitedHealth affiliates used only the medical and surgical modules of the PHCS Database when they reimbursed 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.

Geoziptypes were used to group the charges for a particular CPT code by similar geographical area for summarization and presentation in the database tables. Geoziptypes were based on the first three digits of United States zip codes and were either a single three-digit zip code area or a combination of two or more three-digit zip code areas. Whether a Geozip covered only one or more than one three-digit zip code area was 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 Geoziptypes could vary from year-to-year.

A sample PHCS percentile table is provided below.

CPT Code	Description	50th	60th	70th	75th	80th	85th	90th	95th
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

Important Exclusions

UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases to determine out-of-network benefits for professional services if a member’s health care benefits 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 a member’s plan provides for payment based upon Medicare rates, UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases as a resource for determining payment amounts.

Reimbursement Policies

UnitedHealth affiliates may 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 a member's 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 Group 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.

AWP (Average Wholesale Price) - the Average Wholesale Price for pharmaceutical products which UnitedHealth Group affiliates determine based on a comprehensive database developed and maintained by Thomson Reuters.

FAIR Health - a not-for-profit organization selected by the Attorney General of the State of New York ("NYAG") to provide the health care consumer with data associated with out-of network services.

FH Benchmarking Database – one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "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.

FH RV Benchmarking Database - one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "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..

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 – benefits provided under a health care benefits plan 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., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the PHCS database for determining reimbursement.

MDR database - one of two compilations of information on health care professional charges created by Ingenix, Inc., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the MDR database for determining reimbursement.

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). Ingenix is now known as Optum Insight, Inc.

Optum Insight, Inc. – a wholly-owned subsidiary of UnitedHealth Group (NYSE: UNH). Optum Insight, Inc. was formerly known as Ingenix.

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 UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, OptumHealth, Optum Insight and Prescription Solutions. Through this family of businesses, UnitedHealth Group affiliates serve more than 70 million individuals nationwide.