(DO NOT STAPLE)

CA Large Groups Employee Enrollment Form

UnitedHealthcare*

To speed the enrollment process, please be thorough and fill out all sections that apply.

UnitedHealthcare Insurance Company UnitedHealthcare of California UnitedHealthcare Benefits Plan of California

To Be Completed by Emp	lover		Regu	ested Ef	fective D	ate c	of Cove	erage	/Date o	of Char	nae	1 1
Group Name:							(if applic				<u> </u>	
		Product	Group	#			an Varia			Re	porting Co	de
Date of Hire/	Medical											
Position/Title												
Hours Worked per Week Vision												
Salary \$ Required only if Life, STD or LTD Plan based on salary												
 New Group Plan □ Life Event/Date / / □ Annual □ Status Change Open □ Dependent Add/Delete □ Change Name/Address □ Waiving Coverage □ New Hire □ Active □ Hourly □ Early Re □ Early Re □ COBRA Start date Indicate Quality Ind			yee Type (Check all that apply) ive □ Union □ Non-Union urly □ Salary □ Other ly Retiree □ Retired BRA □ Cal COBRA ate / / End date / / e Qualifying Event all Qualifying Event Date date / / End date / /			Cancellations: Last Date of Employment// Requested Effective Date of Cancellation// □ Cancel all coverage □ Cancel all listed below – Section B (family information) □ Death □ Employee Terminated □ Divorce □ Moved out of service area □ Dependent reached dependent maximum age □ Other (describe)				information) Divorce		
A. Employee Information					Complete complete					ing all	coverage,	olease
Last Name First Nam						urity Number Home F		Home Ph Work Ph				
Address Apt. #		# City	/		State Z		IP .		E-mail address			
1 * * * * * * * * * * * * * * * * * * *			Single acco with						tnamese			
UnitedHealthcare member?	Yes □No the p	ast 12 months	? □Yes	□No	□Korean □Other							
Primary Care Physician ⁽¹⁾ Existin Name: Address						Primary Care Dentist ² Existing Patient □Yes □No Name: ID#						
ID#						1011						
B. Family Information for	Spouse Com	plete all sec	tions for	all family	members.							
Relationship ⁽³⁾ Last Name Spouse/		First Nam	ne				MI	Sex □M		Date of	Birth /	
Domestic Partner Social Security Number							Used tobacco within the last 12 months? □Yes □No					
Check Appropriate Address (if differen	nt from Employee)					Preferred Language: □English □Spanish □Chinese □Vietnamese □Korean □Other				nese		
Box □Enroll Name:	sician ⁽¹⁾		•	g Patient □Yes □No			Primary Care Dentist ⁽²⁾ Existing Patient □Yes □No Name:					
☐Cancel Address						_ ID#						
ID#												

IMPORTANT: (1) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) For court-ordered dependent, legal documentation must be attached. (4) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber/covered person for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

	st, First Name _			SSN							
B. Family I	Information fo	or Dependents"	Complete all secti	ons for all family m	nembers. ((Attac	h sheet if n	ecessary)			
Relationship ⁽³⁾ Dependent	Last Name		First Name			MI	Sex □M □F	Date of Birth			
	Social Security N	Number			Perman	nently [Disabled an	d age 26 or older	⁽⁴⁾ □Yes □No		
Check Appropriate	Address (if differ	rent from Employee)			Used to	bacco	within the la	ast 12 months?	□Yes □No		
Box								inglish □Spanish			
□Enroll	Primary Care Ph	er raigion ⁽¹⁾	Existing Patient		+		Dentist ⁽²⁾	Other	tient Yes No		
		nysician	•		Name:						
5- 1	1				ID#						
					Ιυπ						
Relationship ⁽³⁾ Dependent	Last Name		First Name			MI	Sex □M □F	Date of Birth			
-	Social Security N							d age 26 or older			
Check Appropriate	Address (if differ	rent from Employee)			Used tobacco within the last 12 months? □Yes □No						
Box □ □Enroll					□Vietn	amese	⊠Korean	English □Spanish □Other			
	Primary Care Ph	•	Existing Patient		1 '		Dentist ⁽²⁾	•	itient □Yes □No		
- Change	Name:										
					ID#						
Dependent	Last Name		First Name			MI	Sex □M □F	Date of Birth			
	Social Security N				+			d age 26 or older			
Appropriate	Address (if differ	rent from Employee)						ast 12 months?			
Box ☐ □Enroll _								English □Spanish □Other			
□Cancel	Primary Care Ph	•	Existing Patient		1 '	Primary Care Dentist ⁽²⁾ Existing Patient □Yes □No					
	Name:	Name:_	Name:								
	Address										
□ Change	1				ID#						
□ Change	1				ID#						
IMPORTANT: a Primary Ca products requ and the deper	ID#		to select a Primary C e the Dental Directory . (3) For court-ordered unmarried, chiefly dep	Care Physician for yo y to select a Primary d dependent, legal do bendent upon subscr	ourself and y Care De ocumentate	nd each	h of your co or yourself a ust be attack	overed depender and each of your hed. (4) If you ans	nts for products required covered dependent		
IMPORTANT: a Primary Ca products requ and the deper	ID#	the Provider Directory signation. (2) Please uscare Dentist designation by years of age or older, untally disabling injury, ill Please che a choice of	to select a Primary C e the Dental Directory . (3) For court-ordered unmarried, chiefly dep	Care Physician for yo y to select a Primary d dependent, legal do pendent upon subscr ease attach a medica coverage in which yo n plan you are selec	ourself an y Care De ocumentat riber/cover al certificat ou or your cting. Indic	nd each entist for tion mu red pe tion of r depe	h of your co or yourself a ust be attack rson for sup disability. ndents are e dollar am	overed depender and each of your hed. (4) If you ans oport and is not a enrolling. If your ount selected fo	ats for products required covered dependent swered "Yes" for Disable to be self-support		
IMPORTANT: a Primary Ca products requ and the deper because of a	ID#	the Provider Directory signation. (2) Please uscare Dentist designation by years of age or older, untally disabling injury, ill Please che a choice of	to select a Primary C e the Dental Directory . (3) For court-ordered unmarried, chiefly dep ness or condition, pleace eck the box for each c	Care Physician for yo y to select a Primary d dependent, legal do pendent upon subscr ease attach a medica coverage in which yo n plan you are selec	ourself an y Care De ocumentat riber/cover al certificat ou or your cting. Indic	nd each entist for tion mu red pe tion of r depe cate th Life, S emplo	h of your co or yourself a ust be attack rson for sup disability. ndents are the dollar am Short- Term yer selection	overed depender and each of your hed. (4) If you ans oport and is not a enrolling. If your ount selected fo	ats for products required covered dependent swered "Yes" for Disable to be self-support		
IMPORTANT: a Primary Ca products requ and the depei because of a	ID#	the Provider Directory signation. (2) Please use Care Dentist designation by years of age or older, untally disabling injury, ill Please che a choice of Accidental Disability (L	to select a Primary C e the Dental Directory . (3) For court-ordered unmarried, chiefly dep ness or condition, pleach eck the box for each c plans, indicate which Death & Dismemberr LTD) plans. Benefit of	Care Physician for you to select a Primary of dependent, legal do bendent upon subscrease attach a medical coverage in which you held plan you are selected ment (AD&D), Suppefferings are depended.	ourself an y Care De ocumentat riber/cover al certificat ou or your cting. Indic olemental	nd each entist for tion mu red pe tion of r depe cate th Life, S emplo	h of your coor yourself a ust be attack rson for sup disability. Indents are the dollar am Short- Term yer selections Supply Su	overed depender and each of your hed. (4) If you and oport and is not a enrolling. If your rount selected fo Disability (STD) on.	ents for products required covered dependent swered "Yes" for Dissiple to be self-supposed employer offers right the Life and and Long-Term Voluntary AD&		
IMPORTANT: a Primary Ca products requ and the depel because of a C. Product Person Employee Spouse/Don	ID#	the Provider Directory signation. (2) Please use Care Dentist designation by ears of age or older, use the control of the cont	to select a Primary Cree the Dental Directory. (3) For court-ordered unmarried, chiefly depiness or condition, pleack the box for each ciplans, indicate which Death & Dismemberr LTD) plans. Benefit of Dental	Care Physician for you to select a Primary of dependent, legal do bendent upon subscriase attach a medical coverage in which you plan you are select ment (AD&D), Supp fferings are dependent of the primary of the prim	ourself an y Care De ocumentat riber/coveral certificat ou or your cting. Indicolemental lent upon e Basic Lif	nd each entist for tion mired pe tion of r depe cate th Life, S emplo	h of your coor yourself aust be attack rson for sup disability. Indents are the dollar am short- Term yer selection with the supplementation of the supplementa	enrolling. If your ount selected fo Disability (STD) on.	ents for products required covered dependent swered "Yes" for Disable to be self-supported in the Life and and Long-Term Voluntary AD&I \$\$		
IMPORTANT: a Primary Ca products requ and the deper because of a C. Product Person Employee Spouse/Don Dependent	ID#	the Provider Directory signation. (2) Please use Care Dentist designation by years of age or older, use that the disabling injury, ill Please che a choice of Accidental Disability (Linear Medical	to select a Primary Cree the Dental Directory. (3) For court-ordered unmarried, chiefly depiness or condition, pleack the box for each ciplans, indicate which Death & Dismemberr LTD) plans. Benefit of Dental	Care Physician for yo to select a Primary of dependent, legal do bendent upon subscrusse attach a medical coverage in which yo h plan you are selected ment (AD&D), Supp fferings are dependent of the primary of the plan you are selected ment (AD&D), Supp fferings are dependent of the plan you are selected ment (AD&D), Supp fferings are dependent of the plan you are selected ment (AD&D), Supp fferings are dependent of the plan you are selected to the plan you are selected ment of the plan you are selected to the plan you are selected	ourself an y Care De ocumentat riber/coveral certificat ou or your cting. Indicolemental lent upon e Basic Lif	nd each entist for tion mu red pe tion of r depe cate th Life, S emplo	h of your coor yourself aust be attack rson for sup disability. Indents are dollar am short- Term yer selections Lambda	enrolling. If your ount selected fo Disability (STD) on.	ents for products required covered dependent swered "Yes" for Disable to be self-supposed in the Life and and Long-Term Voluntary AD&I \$\$ \$\$ \$\$		
IMPORTANT: a Primary Ca products requ and the depel because of a C. Product Person Employee Spouse/Don	ID#	the Provider Directory signation. (2) Please use Care Dentist designation by ears of age or older, use the control of the cont	to select a Primary Cree the Dental Directory. (3) For court-ordered unmarried, chiefly depiness or condition, pleack the box for each ciplans, indicate which Death & Dismemberr LTD) plans. Benefit of Dental	Care Physician for you to select a Primary of dependent, legal do bendent upon subscriase attach a medical coverage in which you plan you are select ment (AD&D), Supp fferings are dependent of the primary of the prim	ourself an y Care De ocumentat riber/coveral certificat ou or your cting. Indicolemental lent upon e Basic Lif	nd each entist for tion mared pe tion of r depe cate th Life, S emplor fe/AD8	h of your coor yourself a ust be attacked as the control of the coordinate of the co	enrolling. If your ount selected fo Disability (STD) on.	ents for products required covered dependent wered "Yes" for Dissiple to be self-supposed in the Life and and Long-Term Voluntary AD& S Required only		

LG.EE.18.CA 1/18 Page 2 of 6

Primary Secondary

Subscriber Last, First Name	criber Last, First Name SSN							
Prior Medical Insurance/Health Plan Coverage Information This section must be completed to receive credit for prior medical insurance/health plan coverage.								
Within the last 12 months, have you, your spouse/domestic \square NO \square YES (If YES, please complete this section and a		•	iny other medic	al coverage?				
Prior medical carrier name Effective date// End date//_								
Policy # (if applicable)								
Prior coverage type: ☐ Employee ☐ Spouse/Domes Have you met any of your calendar year deductible? ☐ Ye previous insurance company/health care service plan.)				on of Benefits/Explanation of Payment from the				
E. Other Medical Insurance/Health Plan Coverage Information This section must be completed. (Attach sheet if necessary.)								
On the day this coverage begins, will you, your spouse/dom policy, including another UnitedHealthcare plan or Medicare	e?		idents be cover	ed under any other medical health plan or				
\square YES (continue completing this section) \square NO (If NO, Name of other carrier		-	her carrier polic	·v#				
Other Medical Insurance/Health Plan				Name and date of birth of policyholder/				
Coverage Information	Type	Effective Date	End Date	covered employee for other insurance/				
(only list those covered by other plan)	(B/S/F) [†]	MM/DD/YY	MM/DD/YY	health plan coverage				
Employee:		1 1	1 1					
Spouse/Domestic Partner Name:		1 1	1 1					
Dependent Name:		1 1	1 1					
Dependent Name:		1 1	1 1					
Dependent Name:		1 1	1 1					
*B. Enter 'B' when this dependent is covered under both you an S. Enter 'S' if you are the parent awarded custody of this depe F. Enter 'F' if this dependent is covered by another individual (ndent and no other	er individual is requi our household) req	red to pay for th juired to pay for	is dependent's medical expenses.				
Medicare – Employee Information: (If enrolled, pl	ease attach a co	py of your Medica	ire ID card.)					
Medicare ID#								
☐ Enrolled in Part A: Effective Date/	•			Part A (chose not to enroll) Part B (chose not to enroll)				
☐ Enrolled in Part D: Effective Date/ ☐ In	•			Part D (chose not to enroll)				
Reason for Medicare eligibility: Over 65 Kidney D	abled	☐ Disabled but actively at work Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date / /						
Medicare – Spouse/Domestic Partner/Dependent Name:		(If e	(If enrolled, please attach a copy of your Medicare ID card.)					
Medicare ID# □ Enrolled in Part A: Effective Date / _ / □ In		Δ* Π	Not Enrolled in	Part A (chose not to enroll)				
☐ Enrolled in Part B: Effective Date/ ☐ In			☐ Not Enrolled in Part A (chose not to enroll)☐ Not Enrolled in Part B (chose not to enroll)					
☐ Enrolled in Part D: Effective Date/ _/ ☐ Ir	-			Part D (chose not to enroll)				
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney D	Reason for Medicare eligibility: Over 65 Kidney Disease Disabled Disabled but actively at work							
*Only check "Ineligible" if you have received documentation fi	rom vour Social S	Security benefits th	at indicate that	you are not eligible for Medicare.				

LG.EE.18.CA 1/18 Page 3 of 6

Subscriber Last, First Name					SSN						
F. Waiver of Coverage			Complete only if you are waiving coverage for yourself and/or any family member.								
I decline all coverage for:	Medical	Dental	Vision	Basic Life/ AD&D	Supp Life/ AD&D	Vol. AD&D	STD	LTD	STD Buy up	LTD Buy up	
Myself											
Spouse/Domestic Partner											
Dependent Children											
Myself and all dependents											
Declining coverage due to existend	e of other o	coverage:									
 □ Spouse's Employer's Plan □ Covered by Medicare □ COBRA from Prior Employer □ I (we) have no other coverage at 	oyer's Plan] Individual Plan] Medicaid] Cal-COBRA] Other			☐ Tri-Care ☐ VA Eligibility ☐ Cal-COBRA AB				
Any references to Preexisting C	Conditions	do not a	apply to a	nyone under	the age of	19 whose pla	n is subject	to healt	h care refor	m contained in	
INDIVIDUAL HEALTH INSURANCOR YOU COULD BE DECLINED I acknowledge that the available the chance to apply for coverage. partner and/or my dependent(s) in pressure on me to decline covera ENROLLED IN THE GROUP ME ENTITLED TO AN OFF-CYCLE IN OR LOSS OF OTHER COVERAGE.	coverages I have decome my emploge. I ACKN DICAL PLA ENROLLMI GE THROU	have beed ided not byer healt NOWLED AN. THE ENT PER	RELY. en explain- to enroll n h plan. I h GE THAT WAIT OF RIOD DUE EPENDEN	ed to me by m nyself and/or n nave made this MY DEPEND UP TO TWEL TO CERTAIN IT.) The twelve	y employer ny depender decision vo ENTS AND LVE (12) MC I CHANGED e (12)-month	and I know thant(s), if any. I rolluntarily, and I MAY HAVE DITHS WILL I DERCUMSTA	at I have bee now decline to no one has to TO WAIT UNOT APPLY ANCES (E.G. apply if:	n given to enroll ried to in P TO TW IF I ANI , ACQU	the right and myself, my s fluence me c VELVE (12) I D/OR MY DE ISITION OF	have been given pouse/domestic or put any MONTHS TO BE PENDENTS ARE A DEPENDENT	
 I certify at the time of initial en Medi-Cal coverage was the re- no share-of-cost Medi-Cal; 											
2. my employer offers multiple he	ealth benefi	t plans a	nd I electe	ed a different p	lan during a	n open enrollr	ment period;				
3. a court orders that I provide co	overage un	der this p	lan for a s	spouse or mind	or child; or						
4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 30 days after the marriage, domestic partnership, birth, adoption or placement for adoption.											
	If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).										
Employee Signature (only if waivi	ng coverag	e for self	and/or de	ependents)				Date			
								_	/	/	

LG.EE.18.CA 1/18 Page 4 of 6

Subscriber Last, First Name	SSN							
G. Authorization to Release Medical Information and Si	gnature							
Your enrollment in the plan is expressly conditioned upon your accept the following terms and conditions, you may not complete your enrolln TERMS AND CONDITIONS		ollment application. If you do not agree to						
As a condition of my and/or my dependents' participation in the plan, a for myself and/or for my dependents as follows:	and in consideration for the privileges that come from	participation in the plan, I hereby agree						
recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for any claims including personal injury or death, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS DBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.								
recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.								
I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment.								
I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contrib								
Please maintain a copy of this authorization for your records. Employee Signature	Employee Name (please print)	Date						
H. Binding Arbitration I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.								
Employee Signature (Required)	Employee Name (please print) (Required)	Date (Required)						
LG.EE.18.CA 1/18	Page 5 of 6							

Subscriber Last, First Name		SS	N
I. Census Information			
NOTE: Data collected in this sect being. This information will not be			es and inform them of specific programs to enhance their well-
Race, check all that apply:	☐ White☐ Native Haw☐ Hispanic/La	☐ Black, African-American ⁄aiian/Pacific Islander atino	□ American Indian/Alaska Native □ Asian □ Other Race, please specify
Health plan coverage provided by or th	rough UnitedHealthcare	Insurance Company, UnitedHealthcare	Benefits Plan of California and UnitedHealthcare of California. Administrative

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

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.