UnitedHealthcare Choice

Summary Plan Description

Health Maintenance Organization (HMO) Plan

For the State Health Benefit Plan (SHBP)

Effective: January 1, 2016
Group Number: 902786

TABLE OF CONTENTS

MEDICAL CLAIMS ADMINISTRATOR

SECTION 1 - WELCOME - - -

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient - - - - 34
Mental Health Services - - - -

Services Provided under Another Plan - - -

SECTION 1 - WELCOME

Please make note of the following information that contains UnitedHealthcare department names and telephone numbers:

- Member services, claim inquiries, Prior Authorization/Personal Health Support and Mental Health/Substance Use Disorder, call (888) 364-6352; as shown on your Member ID Card. The TDD phone number is (800) 255-0056;
- Claims submittal address:
  UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800;
- Online assistance: www.myuhc.com.
- For detailed explanation on Prior Authorization please see Section 3, *Personal Health Support and Prior Authorization*; and
- For SHBP Member Services, call (800) 610-1863 Monday – Friday, 8:30 a.m. - 5:00 p.m. ET.

This booklet is your Summary Plan Description (SPD) and describes the provisions of the State Health Benefit Plan (SHBP) and this Choice Health Maintenance Organization (HMO) Plan under the State Health Benefit Plan. This Choice HMO Plan is referred to in this booklet as the "Choice HMO" and the State Health Benefit Plan is referred to as the "SHBP" or "the Plan." You have this SPD because you are enrolled in the Choice HMO Plan under the SHBP. Use this SPD as a reference tool to help and maximize your coverage. If you have questions contact UnitedHealthcare at the number on the back of your ID card. Call UnitedHealthcare if you have questions about the limits of the coverage available to you.

Note: Please refer to the Eligibility and Enrollment Provisions booklet that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.dch.georgia.gov/shbp-plan-documents.

The SHBP is self-insured Plan, and is governed by certain Georgia laws, the regulations of the Department of Community Health (DCH) Board, Chapter 111-4-1 Health Benefit Plan, and resolutions of the Board of Community Health that establish required contributions that must be paid to the SHBP. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

This booklet is notice to all Covered Persons of the Plan's benefits payable under the Choice HMO Option for services provided on or after January 1, 2016, unless otherwise noted. Any and all statements to Covered Persons or to providers about payment or levels of payment that were made before January 1, 2016 are canceled if they conflict in any way with the provisions described in this booklet.

DCH is the Plan Administrator, and reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the Medical Claims Administrator. The Plan Administrator has delegated full responsibility for medical claims administration to UnitedHealthcare. UnitedHealthcare processes and pays claims in accordance with the terms of the Plan, including this booklet and the separate medical and reimbursement policy guidelines that serve as supplement to this booklet to more fully define eligible charges. UnitedHealthcare has the discretion to interpret the terms of the Plan when processing and paying claims and makes final decisions with respect to medical claims.

DCH also reserves the right to modify the benefits, level of benefit coverage and eligibility/participation requirements for the Plan at any time, subject only to reasonable notification to Covered Persons. When such a change is made, it will apply as of the modification's effective date to any and all charges incurred by Covered Persons on that day and after, unless otherwise specified by DCH.

IMPORTANT NOTE:
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 11, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

For more information about your Pharmacy Benefits see the "Outpatient Prescription Drug Rider" Section of this SPD or go to your Pharmacy Claims Administrators website, Express-Scripts.com/GeorgiaSHBP. For more information about your Wellness Benefits, see the "Well- Being Incentive Programs" in the Healthways Section of this SPD or go to the Wellness Program Administrators website, www.BeWellSHBP.com. These benefits are not administered by UnitedHealthcare.

Fraud and Abuse

Please notify the Plan of any fraudulent activity regarding Plan Covered Persons, providers, payment of benefits, etc. at (866) 242-7727.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 11 *Glossary*. You can refer to Section 14 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to the Department of Community Health, Division State Health Benefit Plan (SHBP). When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in Section 11, *Glossary*.

To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference. If you have questions contact UnitedHealthcare at the number on the back of your ID card. You should call UnitedHealthcare if you have questions about the limits of the coverage available to you.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.
- You can find copies of your SPD and any future amendments at www.dch.georgia.gov/shbp-plan-documents or request printed copies by contacting SHBP Member Services at (800) 610-1863.
- Capitalized words in the SPD have special meanings and are defined in Section 11, *Glossary*. If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 11, *Glossary*.

Membership Correspondence and Appeals for eligibility issues (other than medical or pharmacy claims):

State Health Benefit Plan
Membership Correspondence Unit
P.O. Box 1990, Atlanta, GA 30301-1990

Note: For these forms and procedures, go to www.dch.georgia.gov/shbp .

Membership Correspondence for issues related to completing the 2015 Healthways Well-Being Assessment®:

For more information about your Wellness Benefits, see the "Well-Being Incentive Programs" in the Healthways Section of this SPD or go to the Wellness Program Administrator's website, www.BeWellSHBP.com.

Membership Correspondence for issues related to Medical Claim Appeals

Please see Section 8, *Claims Procedures, Claim Denials and Appeals* on how to appeal an adverse determination.

Requests for Review of Denied Claims/Appeals and Notice of Complaints:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

Note: UnitedHealthcare reserves the right to request medical records and any other supporting documentation for medical claims submitted.

Express Scripts Member Services

Prescription drug pharmacy benefits are administered separately by the Pharmacy Claims Administrator, Express Scripts. Please see the "Outpatient Prescription Drug Rider" in thisSPD. Prescription drug written appeals and inquiries should be directed to:

Express Scripts Appeal Department
State of Georgia Health Benefit Plan Members
P.O. Box 66588, St. Louis, MO 63166-6588

STATE HEALTH BENEFIT PLAN (SHBP) CONTACT / RESOURCES INFORMATION		
	Member	**Website**
Medical Claims Administrator – United Healthcare Services, Inc. 9900 Bren Road East Minnetonka, MN 55343 Member Service Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday MH/SA Hours: 8:00 a.m. – 6:00 p.m. ET Monday – Friday NurseLine: 24 hours a day/ 7 days a week Fraud Hotline	(888) 364-6352 TDD (800) 255-0056 (800) 242-7727	www.myuhc.com
Wellness Program Administrator-Healthways Member Service Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday Healthways Corporate Compliance	(888) 616-6411 (866) 225-0836	www.BeWellSHBP.com
Pharmacy Claims Administrator-Express Scripts Member Service Hours: 24 hours a day / 7 days a week Fraud Tip Hotline	(800) 922-1557 (866) 216-7096	www.Express-Scripts.com/GeorgiaSHBP email: fraudtip@express-scripts.com
SHBP Member Services Hours: 8:30 a.m. – 5:00 p.m. ET Monday – Friday	(800) 610-1863	www.mySHBPga.adp.com
Additional Information		
Centers for Medicare & Medicaid (CMS) 24 hours a day / 7 days a week	(800) 633-4227 TTY (877) 486-2048	www.medicare.gov

SECTION 2 - HOW THE PLAN WORKS

This section includes:

- Wellness Incentives for Health, Administered by Healthways
- Accessing Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum

The purpose of this Health Maintenance Organization Plan Option is to pay most medically necessary care and treatment of illness and accidental Injury for Covered Persons by Network providers only after a copayment for certain services has been satisfied. Covered Services by Network providers only in an outpatient or inpatient basis require deductible and coinsurance. This Plan Option is a Network provider only option. Medical claims properly coded as Preventative Care and received from a Network provider are not subject to a copayment.

Wellness Incentives for Health, Administered by Healthways

Earn well-being incentive credits for wellness activities. SHBP Covered Persons and covered spouses can each earn up to 480 well-being incentive credits in a Health Incentive Account (HIA) for completing health actions. That is a total of up to 960 well-being incentive credits, if both you and your covered spouse complete all required activities. The well-being incentive credits can be used for eligible health care expenses once you have satisfied a portion of your deductible. See the Healthways section of this SPD.

The well-being incentive credits can be used for Covered Health Services. As you complete each activity, your well-being incentive credits will be deposited in the HIA one month after completion. To earn your well-being incentive credits, complete the activities listed below between January 1, 2016 and December 15, 2016.

What to do		What you earn
1.	**ASSESS YOUR HEALTH** Complete your 2016 Healthways Well-Being Assessment® (WBA), a confidential, online questionnaire that will take about 20 minutes.	**Complete <u>BOTH</u> and earn 240** well-being incentive credits. (*WBA must be completed before any incentive can be earned*)
2.	**KNOW YOUR NUMBERS** Complete a 2016 biometric screening and submit results (body mass index, blood pressure, cholesterol, glucose). The biometric screening must be completed at an SHBP sponsored screening event or by your physician and your results submitted appropriately on the 2016 Physician Screening Form.	
3.	**TAKE ACTION** It's your choice! Complete the coaching or online pathway, or a combination of both. **<u>COACHING PATHWAY</u>** Complete your WBA and Actively engage in telephonic coaching. **<u>ONLINE PATHWAY</u>** Create your WBA and, Record five online well-being activities using the same tracker within four consecutive weeks and earn 40 well-being incentive credits. You can earn these rewards up to six times. A sample online activity would be to track your daily steps five times within four consecutive weeks.	**Earn up to 240** well-being incentive credits. (*WBA must be completed before any incentive can be earned*)

Maximum well-being incentive credits: You - 480 | You + Child(ren) - 480 | You + Spouse - 960 | Family – 960

Special note: Additionally, UnitedHealthcare will match up to an additional 240 well-being incentive credits into your HIA when the employee only (not the covered spouse) completes all three of the above Healthways health actions.

Using the Health Incentive Account (H IA) for the H M O

When you complete a health action with the Wellness Program Administrator, well-being incentive credits will be placed into your HIA, one month after completion.

If you have a copayment, deductible or co-insurance payment, we will automatically use the well-being incentive credits in your HIA to help reimburse you the cost. You will receive a check from UnitedHealthcare for the reimbursement.

The well-being incentive credits will automatically be used until they are gone. Then you will need to pay any remaining amount out of your pocket.

NOTE: Using the HIA for outpatient prescription drugs filled at a Pharmacy:
As pharmacy benefits are administered separately by the Pharmacy Administrator, Express Scripts, you will need to pay out-of- pocket for your prescriptions. If you have well-being incentive credits in your HIA, we will automatically reimburse you from your account as outlined above.

Accessing Network Benefits & How This Choice HMO Option Works

This Choice HMO Option offers network only benefits and provides major medical, treatment of illness including pharmacy coverage only when using Network providers (except in cases of emergencies). This Plan features certain services that are subject to a deductible, co-insurance and copayments. Copayments count towards your Out-of-Pocket maximum: however, do not count towards your deductible. Although you are not required to obtain a referral to a specialist (SPC), you are encouraged to select a Primary Care Physician (PCP) to help coordinate your care.

Your health plan requires you to pay a copayment each time for certain Covered Health Services. Other Covered Health Services require you to meet an annual deductible before you are eligible for benefits under the Plan. This means that when you visit a provider, you are responsible for either a copayment at the time of service or the costs associated with Covered Health Services until you meet your annual deductible. Services performed in the office, during the visit will be covered under the copayment. No copayment applies when no Physician charge is assessed for some selected services. For certain services, once your annual deductible has been met for the year, Covered Health Services are payable at a certain percentage of eligible expenses. Refer to Section 4, *Plan Highlights* for Benefit Information details. The maximum amount an individual can apply to the deductible is shown in Section 4, *Plan Highlights*, "Individual", "Individual plus one" or "Family" deductible amount. Copayments do not count toward your deductible but do apply towards your out-of-pocket maximum.

Network providers are not UnitedHealthcare agents or employees, nor are they agents or employees of UnitedHealthcare. The relationships between UnitedHealthcare and Network providers are solely contractual relationships.

Important Note: All services must be received by a Network Providers, except in cases for emergency care. Non-Emergency use of the emergency room is covered. If you choose to receive services from a Non-Network provider, you are responsible for all charges, except for Emergency Health Services. If you receive services from a network provider, the provider will submit the bill to UnitedHealthcare for payment. Although you are not required to obtain a referral to a specialist (SPC), you are encouraged to select a PCP to help coordinate your care.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider only.

Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits. Benefits always include Emergency Health Services that are

provided by a Network or non-Network provider.

Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under Eligible Expenses as described in this Section. As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount the Medical Claims Administrator determines to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

Eligible Expenses

Georgia Department of Community Health has delegated to the Medical Claims Administrator, UnitedHealthcare, the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

However, the Plan Administrator and UnitedHealthcare do not have the legal authority to intervene when Non-Network Providers bill you. As a result, we cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are billed by Non-Network Providers.

For Network Benefits, Eligible Expenses are based on the following:

- when Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- when Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received **at a Network facility** on a non-Emergency basis **from a Non-Network facility based Physician**, the Eligible Expense is based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market

When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense may be based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card!
Remember to show your UnitedHealthcare Member ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Transition of Care
If you are under the care of a non-Network provider on the effective date of this SPD, you may be eligible for reimbursement at the Network level of Benefits with that provider for a period of time for 1st, 2nd or 3rd trimester pregnancy situations. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please call the toll-free number on your ID card.

Health Services from Non-Network Providers
If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare. UnitedHealthcare will confirm that care is not available from a Network provider and will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services received from a non-Network provider as the care was coordinated between UnitedHealthcare and the Network Physician.

Looking for a Network Provider?
In addition to other helpful information, www.myuhc.com**,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information.

Limitations on Selection of Providers
If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you.

In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a dollar limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the amount used toward meeting the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example

Assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of- Pocket Maximum?
Copays, even those for covered outpatient prescription drugs provided in a separate prescription drug plan administered by Express Scripts	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

This section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services which Require Prior Authorization. In general, Network providers are responsible for obtaining prior authorization before they provide certain health services to you.

Care Management

When you seek prior authorization as required, UnitedHealthcare will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents. Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available, including the use of Network Providers to help lower your out-of-pocket costs.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions or your overall health.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization Requirements

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 5, *Additional Coverage Details* within each Covered Health Service category.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. **Network facilities and Network providers cannot bill you for services they fail to prior authorize as required.** You can contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

To obtain prior authorization from UnitedHealthcare by contacting Personal Health Support at (888) 364-6352. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical

necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

In most cases, Network providers are responsible for obtaining prior authorization from UnitedHealthcare or contacting Personal Health Support before they provide these services to you. However, you are responsible for obtaining prior authorization from UnitedHealthcare prior to receiving a service for:

- ambulance – non-emergency air;
- Clinical Trials;
- Congenital Heart Disease Surgeries;
- Applied Behavioral Analysis (ABA); and
- Transplants

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For prior authorization timeframes and any reductions in Benefits if you do not get prior authorization from UnitedHealthcare, see Section 5, *Additional Coverage Details*.

Please note: Prior Authorization is required even if you have a referral from your Primary Care Physician to seek care from another Network Physician.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, UnitedHealthcare's final coverage determination will be modified to account for those differences, and the Plan will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Special Note Regarding Medicare

Prior authorization is required for transplant services, even if Medicare is primary, and for expenses that Medicare does not cover. Call UnitedHealthcare at the number on the back of your card whenever you need mental health and substance abuse care, even if you have primary coverage through Medicare or a health plan other than SHBP.

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from UnitedHealthcare before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB)*.

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network
Copays[1] ■ Physician's Office Services – Primary Care Physician ■ Physician's Office Services - Specialist ■ Rehabilitation Services ■ Chiropractic/Spinal Manipulation ■ Urgent Care Center Services ■ Virtual Visit ■ Emergency Health Services - Outpatient	 $35 $45 $25 $45 $35 $35 $150
Annual Deductible[1 2] ■ You ■ You + Child(ren) or You + Spouse ■ You + Family (not to exceed the applicable Individual amount per Covered Person) **Note:** The maximum amount an individual can apply to the You, You + Spouse, You + Child(ren) or You + Family Deductible is the You Deductible amount. The Deductible may be satisfied cumulatively.	 $1,300 $1,950* $2,600* *The Deductible amount any one person can satisfy cannot be more than the You Deductible. Once met, claims are paid according to plan guidelines for that individual.
Annual Out-of-Pocket Maximum[1 2 3] ■ You ■ You + Child(ren) or You + Spouse ■ You + Family (not to exceed the applicable Individual amount per Covered Person) **Note:** The maximum amount an individual can apply to the You, You + Spouse, You + Child(ren) or You + Family Out-of-Pocket amount is the You amount.	 $4,000 $6,500* $9,000* *The out-of-pocket amount an individual can meet cannot be more than the You out-of-pocket amount. Once met, Covered Health Services are paid at 100% of Eligible Expenses for that individual. The Out-of-Pocket Maximum can be met cumulatively.

1 In addition to these Copays, you may be responsible for meeting the Annual Deductible and Coinsurance for the Covered Health Services described in the chart on the following pages.

2 Copays do not apply toward the Annual Deductible but do apply towards the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

3 The Annual Out-of-Pocket applies to all Covered Health Services under the Plan, including covered outpatient prescription drugs provided in a separate prescription drug plan administered by Express Scripts.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Ambulance Services ■ Emergency Ambulance	100%
Cancer Resource Services (CRS) ■ Hospital Inpatient Stay	80% after the Annual Deductible
Clinical Trials - Routine Patient Care Costs Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non- Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.
Congenital Heart Disease (CHD) Surgeries ■ **Hospital - Inpatient Stay**	80% after the Annual Deductible
Dental Services - Accident Only and Oral Care Surgery (Copay is per office visit) ■ inpatient and outpatient facility ■ oral surgery performed in Physician's office setting ■ wisdom teeth (fully impacted only) ■ orthognathic surgery to correct obstructive sleep apnea and for Dependents age 19 and under who are born with specific craniofacial syndromes, and as determined by Personal Health Support policies	80% after the Annual Deductible 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting; OR 80% after the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management Items ■ diabetes equipment and related insulin pump supplies See Durable Medical Equipment in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.
Durable Medical Equipment (DME) See Section 5, *Additional Coverage Details*, for limits	100%
Emergency Health Services - Outpatient Emergency services received at a non- Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after a $150 Copay; OR 80% after the Annual Deductible for services to treat a condition that does not meet the definition of an Emergency
Hearing Services and Hearing Aids ■ Hearing examinations, tests and fittings received from a health care provider See Section 5, *Additional Coverage Details*, for limits ■ Hearing aids are covered (with a prescription or documentation of medical necessity or hearing loss). However, telephonic/online hearing tests and evaluations are not covered and are listed as exclusions under the Exclusions section of this SPD. See Section 5, *Additional Coverage Details*, for hearing aid benefit limitations	100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician when received in a Physician's office setting; OR 80% after the Annual Deductible 100% Limited to: $1,500 every 5 years for adults & $3,000 every 5 years for Dependent children (0 up to age 19)

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Home Health Care	100%
Hospice Care See Section 5, *Additional Coverage Details*, for limits	100% after the Annual Deductible
Hospital - Inpatient Stay	80% after the Annual Deductible
Infertility Services (Limited to the diagnostic testing, but once diagnosed, treatment of infertility is not covered by the Plan. Coverage for infertility drugs may be approved for a medical diagnosis not related to infertility treatment if the medical diagnosis meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. UnitedHealthcare must be contacted by your physician to determine coverage). Please also refer to Section 7, *Exclusions*, Reproduction.	80% after the Annual Deductible
Kidney Resource Services (KRS) These Benefits are for Covered Health Services provided through KRS only.	80% after the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient (No Copay applies if no office visit is billed)	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting or 100% for services performed by a Network independent lab
Mental Health Services ■ Hospital - Inpatient Stay & Partial Day Hospitalization ■ Physician's Office Services (Copay is per visit)	80% after the Annual Deductible 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician; OR 100% after a $10 Copay for group and family visit; $45 Copay for Intensive Outpatient Treatment

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Neurobiological Disorders - Autism Spectrum Disorders (ASD) Services ■ Hospital - Inpatient Stay ■ Physician's Office Services Copay is per visit ■ ASD Applied Behavior Analysis (ABA) - Limited to Dependent children to age 10, Prior Authorization is required	80% after the Annual Deductible 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician; OR 100% after a $10 Copay for group and family visit 80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting up to $35,000 per calendar year
Nutritional Counseling See Section 5, *Additional Coverage Details* for benefit limits	100%
Ostomy Supplies	100%
Pharmaceutical Products - Outpatient (billed under your HMO medical Plan)	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting or Urgent Care Center; OR 100% after a $150 Copay for Emergency Health Services
Physician Fees for Surgical and Medical Services (No Copay applies if no office visit is billed)	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting; OR 100% for Physician inpatient services related to Pregnancy – Maternity Services

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Physician's Office Services - Sickness and Injury (Copay is per visit)	
■ Primary Care Physician	100% after a $35 Copay
■ Specialist Physician	100% after a $45 Copay
■ Allergy injections, antigens and serum (no Copay applies if no office visit is billed)	80% after the Annual Deductible; OR 100% after you pay a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting
■ Physician's Virtual Visit – (Sickness and Injury)	100% after a $35 Copay
Pregnancy - Maternity Services	
No Copay applies if no office visit is billed. No Copay to Physician office visits for prenatal care *after* the first visit in which a $35 copayment applies. High risk or complicated prenatal visits may require additional copays per visit.	Benefits will be the same as those stated under each Covered Health Service category in this section, except as detailed below:
■ Ultrasound (initial routine)	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist
■ Newborn (well newborn)	100%
■ Newborn (sick)	80% after the Annual Deductible
■ Circumcision	100% at birth; OR if not done at birth subject coverage is subject to medical necessity
Preventive Care Services that meet requirements of Federal and State law. Certain preventive care services when you use network providers and the service is properly coded as preventive.	
■ Physician Office Services	100%
■ Lab, X-ray or Other Preventive Tests	100%
■ Immunizations (In addition to network providers Covered Persons can obtain immunizations and vaccinations at any of the Georgia Public Health Departments)	100%
■ Breast Pump	100%
■ IUD and Diaphragm (device, fitting and removal)	100%
■ Sterilization	100% for females; OR 80% after the Annual Deductible for males

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Prosthetic Devices See Section 5 *Additional Coverage Details*, for limits	80% after the Annual Deductible
Reconstructive Procedures ■ Physician's Office Services (Copay is per visit) ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services (No Copay applies if no office visit is billed) ■ Prosthetic Devices ■ Surgery – Outpatient	100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician 80% after the Annual Deductible 80% after the Annual Deductible; OR 100% after you pay a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting 80% after the Annual Deductible 80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment (Copay is per visit) See Section 5, *Additional Coverage Details*, for therapy benefit visit limitations	100% after a $25 Copay; OR 100% after a $45 Copay for Manipulative Treatment
Scopic Procedures – Outpatient Diagnostic and Therapeutic No Copay applies if no office visit is billed.	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting or 100%for services performed by a Network independent lab
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 5, *Additional Coverage Details*, for benefit limitations	100%
Substance Use Disorder Services ■ Hospital - Inpatient Stay & Partial Hospitalization Program ■ Physician's Office Services (Copay is per visit)	80% after the Annual Deductible 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician; OR 100% after a $10 Copay for group and family visit; $45 Copay for Intensive Outpatient Treatment

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Surgery - Outpatient No Copay applies if no office visit is billed. Copay is per visit.	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting
Temporomandibular Joint (TMJ) Services Copay is per visit.	Depending where the Covered Health Services are provided, Benefits for TMJ services will be the same as those stated under each Covered Health Services category in this section.
Therapeutic Treatments – Outpatient No Copay applies if no office visit is billed. Copay is per visit	80% after the Annual Deductible; OR 100% after a $35 Copay for Primary Care Physician or $45 Copay for Specialist Physician for services received in a Physician's office setting
Transplantation Services If services rendered by a Designated Facility.	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section
Travel and Lodging If services rendered by a Designated Facility. See Section 5, *Additional Coverage Details*, for benefit limitations.	For patient and companion(s) of patient undergoing cancer or transplant procedures
Urgent Care Center Services Copay is per visit.	100% after a $35 Copay

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network Only
Vision Examinations ■ Medical (eye examinations received from a health care provider, for diagnosis and treatment of eye condition) Note: The Plan covers eyeglasses or contact lenses (first pair only) within 12 months of cataract surgery. See Section 5, *Additional Coverage Details*, for limits	100% after a $35 for Primary Care Physician or $45 Copay for Specialist Physician
■ Routine (Network routine eye exam benefits received from a health care provider) See Section 5, *Additional Coverage Details*, for limits	100% for vision screening which could be performed as part of an examination, once every 24 months
Wigs See Section 5, *Additional Coverage Details*, for limits	100% after annual deductible

[1]In general, your Network provider must obtain prior authorization from Personal Health Support, as described in Section 3, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization from Personal Health Support. See Section 5, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Lab, X-Ray and Diagnostics - Outpatient,* and *Lab, X- Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.*

SECTION 5 - ADDITIONAL COVERAGE DETAILS

This section supplements the second table in Section 4, *Plan Highlights*, and includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization before you receive them Personal Health Support to obtain prior authorization

The tables in Section 4 provide you with Benefit limitations, Copayment, Coinsurance and Annual Deductible for Covered Health Services. This section includes descriptions of the Benefits and include additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 11, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

Non-emergency transportation ground or air transportation of Covered Person to or from a medical facility, Physician's office, or patient's home is excluded, unless approved by Personal Health Support.

Note: Emergency, life threatening, medically necessary ambulance transportation is available to the CLOSEST facility able to treat the condition, even if you are out of the country. If you are traveling outside the U.S. and wish to be transported back into the U.S. for treatment, you may want to consider purchasing travel insurance. If the services are provided at a facility that is not the closest facility able to treat the condition, the SHBP will not assume financial responsibility for the additional transportation charges.

Prior Authorization Requirement

In most cases, the Claims Administrator will initiate and direct non-Emergency ground or air ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 11, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit **www.myoptumhealthcomplexmedical.com.**

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;

- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer related services received at a Designated Facility.

Note: To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials – Routine Patient Care Costs

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of cancer or other life-threatening disease or condition. For purposes of this benefit, a life threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list above.

Prior Authorization Requirement
You must obtain Prior Authorization as soon as the possibility of participation in a Clinical Trial rises. If you fail to obtain Prior Authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about these guidelines.

Prior Authorization Requirement
If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, you must obtain Prior Authorization as soon as the possibility of a CHD surgery arises. If you fail to obtain Prior Authorization as required, Benefits will not be paid.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation; surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or UnitedHealthcare to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact United Resource Networks at (888) 936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if you provide the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network.

Dental Services - Accident Only and Oral Care Surgery

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- a sound and natural or unrestored tooth, or
- a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

NOTE: Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 36 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Oral Care

The Plan will pay benefits only for:

- reconstructive surgical procedures (including dental implants and dentures) for the repair of sound, natural teeth or tissue that were damaged as a result of oral cancer or treatment for oral cancer such as chemotherapy or radiation treatment and other cancer related treatments with Prior Authorization by Personal Health Support;
- surgery to treat lesions of the mouth, lip or tongue, if the lesion requires a pathological examination;
- surgery (frenulectomy) for treatment of a child's speech impairment, when medically indicated;
- surgery of accessory sinuses, salivary glands or ducts,
- surgery to repair cleft palates;
- Orthognathic surgery to correct obstructive sleep apnea and for Dependents age 19 and under born with specific craniofacial syndromes, and as determined by Personal Health Support policies; and
- Institutional and anesthesia charges associated with non-covered dental care normally performed in a dental

office, but due to the patient's medical condition, care in a Hospital setting is warranted, as required under state law.

Repairs that are not performed promptly (as defined) will be denied unless a compelling medical reason exists. X-Rays and other documentation may be required to determine benefit coverage.

The Plan does not cover:

- dental care, except as described above;
- preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums.
  Examples include all of the following:
  - extraction, restoration and replacement of teeth.
  - medical or surgical treatments of dental conditions.
  - services to improve dental clinical outcomes.
  - dental braces.
  - dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

The only exceptions to this are for any of the following:

- transplant preparation.
- initiation of immunosuppressives.
- the direct treatment of acute traumatic Injury, cancer or cleft palate.
- treatment of congenitally missing, malpositioned, or super numerary teeth even if part of a Congenital Anomaly including but not limited to cleft palate.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified in the following table.

Covered Diabetes Services	
Diabetes Self-Management and Training, Diabetic Eye Examinations, Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and related pump supplies and blood glucose monitors for the management and treatment of diabetes, based upon the medical needs of the Covered Person. The medical Plan does not cover the following diabetic self- management items; however, these may be covered under a separate prescription drug plan administered by Express Scripts: ■ insulin; ■ insulin syringes with needles; ■ blood glucose and urine test strips; ■ ketone test strips and tablets; and ■ lancets and lancet devices. Insulin pumps and blood glucose monitors are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary pump supplies as described under *Diabetes Services* in this section;
- compression stockings (limited to two stockings per calendar year);
- diabetic shoes (limited to one pair per calendar year);
- cranial helmets;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery – Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage, except for braces to treat curvature of the spine. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every calendar year.

Prior Authorization is required for electric wheelchairs and scooters. Wheelchairs are only covered every

three years unless reviewed and approved by Personal Health Support in instances when there has been a change in the Covered Person's health status.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the one year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the UnitedHealthcare is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Note: Please remember that you must notify Personal Health Support within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency. If Personal Health Support is not notified, no Benefits will be paid.

True Emergency Eligible Medical Services rendered outside of United States are covered subject to Pla n guidelines.

Non-emergency services are not covered.

All foreign claims and medical records are subject to medical review and should be submitted to:

United Health Group International at Claims
P.O. 740817 Atlanta, GA 30374.

International Claim forms can be obtained at www.welcometouhc.com/shbp.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are described under *Surgery Outpatient* in this section for Covered Persons who have either

of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to every 5 calendar years:

- $3,000 for a Dependent child up to age 19; or
- $1,500 for Covered Person adult

Amounts exceeding the maximum shown above is the Covered Person's responsibility and does not apply to any deductible or out-of-pocket maximum.

Benefits for hearing exams related to an Injury or Sickness are described under *Physician's Office Services - Sickness and Injury* in this section when performed in a Physician's office setting.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 11, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 11, *Glossary* for the definition of Skilled Care.

UnitedHealthcare will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Benefits for Skilled Care are limited up to four hours of Skilled Care services. See Section, *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* in this Section for definition of Skilled Care.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits are limited to 8 visits per calendar year for bereavement counseling.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital- based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Infertility Services

The Plan covers diagnostic testing only, but once diagnosed, treatment of infertility is not covered. Coverage for infertility drugs may be approved for a medical diagnosis not related to infertility treatment if the medical diagnosis meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. UnitedHealthcare must be contacted by your physician to determine coverage.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 11, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (866) 561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery – Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include lab and radiology/x-ray; and mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury in this section when office visit is billed. Benefits for other Physician services

are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Lab, X-Ray and Major Diagnostics – CT Scans, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section when office visit is billed. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

UnitedHealthcare determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. Contact UnitedHealthcare for referrals to providers and coordination of care located on the back of your Member ID card.

The Plan does not cover services at a Residential Treatment Facility, or Transitional Care services related to Mental Health /Substance Use Disorder Services.

Neurobiological Disorders - Autism Spectrum Disorder (ASD) Services

The Plan pays Benefits for psychiatric services for ASD (otherwise known as neurodevelopmental disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of ASD is a Covered Health Service for which Benefits are available as described under the Enhanced Autism Spectrum Disorder benefit below.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.

- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder (ASD) Applied Behavior Analysis (ABA) Benefits

Covered Health Services include enhanced ASD services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).

Prior Authorization is required. Contact UnitedHealthcare for referrals to providers and coordination of care. UnitedHealthcare determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Benefits for Enhanced Autism Spectrum Disorders are limited to Dependent Children to age 10 up to $35,000 per calendar year.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- a knowledge deficit exists regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy);
- diabetes mellitus;
- eating disorders; and
- hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition or mental health condition, except for childhood obesity. This limit applies to non-preventive nutritional counseling services only.

Childhood Obesity

For a Dependent child ages 3 to 18 years: 4 visit limitation per calendar year for physicians and 4 visit limitation per calendar year for registered dietitians who qualify as determined by their Physician.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Ostomy Supplies and Urinary Catheter Supplies

Benefits for ostomy supplies are limited to pouches, face plates and belts; irrigation sleeves, bags and ostomy irrigation catheters; urinary catheters; and skin barriers.

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional.

Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Prescription drug pharmacy benefits are administered separately by the Pharmacy Administrator, Express Scripts. Please see the "Outpatient Prescription Drug Rider" in this SPD.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section. Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Please Note: Your Physician does not have a copy of your SPD, and is not responsible for knowing or

communicating your Benefits.

Pregnancy – Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Dependent daughter's baby charges are not covered by the Plan.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Healthy Moms and Babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for properly coded Preventive care services provided by a Network provider on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your Network provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services. Additional information is available by clicking on the following links:

- For details on Preventive Care Services covered under applicable law visit the Healthcare.gov website at https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults/.
- Another option to view Preventive Care Services specific to age and gender is to visit the UnitedHealthcare preventive care website at http://uhcpreventivecare.com/.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 4, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if the breast pump is obtained from a DME provider or Physician. For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

For a complete listing of covered Preventive Care, see the definition of Preventive Care in the *Glossary*. Preventive services must be billed with appropriate preventive service codes.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Note: Replacement of a type of prosthetic device once every 2-3 calendar years in accordance with UnitedHealthcare clinical guidelines.

Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998.

The Plan pays for new or replacement batteries necessary to operate a covered prosthetic device.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost effective prosthetic device that brings the member to closest baseline functionality. While the plan provides coverage for upper extremity prosthesis, benefits are limited to the most cost effective device that restores baseline functionality.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.

Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 11, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, (when required

by state law) must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal- directed rehabilitation services or if rehabilitation goals have previously been met. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, Autism Spectrum Disorders, or as mandated by Georgia state law. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

The following service is not covered: speech therapy treatment for attention deficit disorders, except for diagnosis and medical management, learning disabilities, developmental delays (except as mandated by

Georgia state law for treatment of Autism Spectrum Disorders) or for speech disorders (such as stuttering) not related to an acute illness.

Benefits are limited to:

- 40 visits per calendar year for physical therapy (The Benefit related to physical therapy is extended beyond 40 visits for Dependent children up to age 19 with Congenital Anomalies that required surgical correction. The Dependent child will also have to be in case management and meet medical necessity criteria.);
- 40 visits per calendar year for occupational therapy;
- 40 visits per calendar year for speech therapy;
- 20 visits per calendar year for Manipulative Treatment (limited to one visit and treatment per day);
- 40 visits per calendar year for pulmonary rehabilitation therapy; and
- 40 visits per calendar year for cardiac rehabilitation therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section when office visit is billed. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service

and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 11, *Glossary*. Benefits are limited to 120 days per calendar year for an Inpatient Stay in a Skilled Nursing Facility. There is no limit for services received in an Inpatient Rehabilitation Facility.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management.
- Crisis intervention.
- Partial Hospitalization/Day Treatment; and
- Intensive Outpatient Treatment.

The Plan does not cover services at a Residential Treatment Facility, or Transitional Care services related to Mental Health /Substance Use Disorder Services.

UnitedHealthcare determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact UnitedHealthcare for referrals to providers and coordination of care.

Surgery – Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits are not available for charges or services that are dental in nature, including appliances and orthodontic care.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments – Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* when office visit is billed.

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal;
- multiple organ transplants (called multi-visceral transplants); and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to obtain Prior Authorization from United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at 888-936-7246 or Personal Health Support at the telephone number on your Member ID card for information about these guidelines.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with transplantation-related services received at a Designated Facility.

Prior Authorization Requirement

You must obtain Prior Authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain Prior Authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to transplantation services and cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by

Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include airfare at coach rate, taxi or ground transportation; or mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments and transplant procedures during the entire period that person is covered under this Plan.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 11, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every 24 months.

Virtual Visits

When you don't feel well, or your child is sick, access to care online at any time with a virtual visit. A virtual visit lets you see and talk to a participating doctor from your computer or mobile device without an appointment. Information will be available on myuhc.com® and through the UnitedHealthcare Health4Me® app in 2016. Use virtual visits when your doctor is not available, you become ill while traveling, or when you are considering visiting a hospital emergency room for a non-emergency health condition.

Virtual visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Conditions commonly treated through a virtual visit are a bladder infection/ urinary tract infection, bronchitis, cold/flu, diarrhea, migraine/headaches, pink eye, and sinus problems.

Access to virtual visits and prescription services may not be available in all states or for all groups. Services

may not be available at all times or in all locations. Go to myuhc.com for more information about availability of virtual visits and prescription services. Virtual visits are an internet-based service provided by contracted UnitedHealthcare providers that allow members to select and interact with independent physicians and other health care providers. It is the member's responsibility to select health care professionals. Care decisions are between the consumer and physician.

Copayment for the virtual visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately. No controlled substances may be prescribed. Other prescriptions may be available where clinically appropriate and permitted by law, and can be transmitted to the pharmacy of the member's choice.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from cancer and/or chemotherapy.

Benefits are limited to $750 per Covered Person per lifetime.

SECTION 6 - RESOURCES TO HELP YOU STAY HEALTHY

The Medical Claims Administrator, UnitedHealthcare, has made several convenient educational and support services, accessible by phone and the internet to help you:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare is not responsible for the results of your decisions from the use of the information, including, but not limited to, you choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Georgia Department of Community Health has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. When you call, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, call the toll-free number on the back of your Member ID card.

With NurseLine℠, you also have access to nurses online. To use this service, log onto www.myuhc.com and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Example: Your child is running a fever and it is 1:00 AM. What do you do? Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;

- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer; and
- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto www.myuhc.com or call the toll- free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. You can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;

- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered, simply go to www.myuhc.com and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:
- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (866) 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services* (CRS).

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:
- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are

receiving the appropriate care; and

- toll-free access to and one-on-one support from a registered nurse who specializes in your condition.

Examples of support topics include:
- meducation about the specific disease and condition,
- medication management and compliance,
- reinforcement of on-line behavior modification program goals,
- preparation and support for upcoming Physician visits,
- review of psychosocial services and community resources,
- caregiver status and in-home safety,
- use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

DISEASE MANAGEMENT (DM) PHARMACY PROGRAM

UnitedHealthcare and Express Scripts have a Disease Management (DM) Pharmacy Copay Waiver Program. Pharmacy cost shares for certain prescription drugs will be waived for Members who actively participate in this program. The goal is to encourage Members to actively work on managing their condition and their overall health.

All Members enrolled in the UnitedHealthcare HMO option who are diagnosed with one or more of the following three conditions are eligible to participate in this program:

- Diabetes
- Coronary Artery Disease (CAD)
- Asthma

Members must actively participate in a Disease Management program, as confirmed by the UnitedHealthcare nurse, and complete the following:

- Complete the Health Information Profile (assessment) with a UnitedHealthcare nurse.
- Complete the Healthways Well-Being Assessment (Healthways is an external vendor providing Lifestyle Management Coaching to SHBP Members. The Well-Being Assessment® is a confidential, online questionnaire that will take the Member about 20 minutes to complete).
- Actively participate in scheduled coaching calls with the UnitedHealthcare nurse (minimum 1 call each calendar month).

If you have diabetes, asthma, and/or coronary artery disease & interested in participating in the program and to learn more about how to qualify, call UnitedHealthcare at (888) 364-6352.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 11,

Glossary under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Management Services

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the toll-free number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- enrollment by an OB nurse;
- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Tobacco Surcharge

Tobacco surcharges are included in all SHBP Options. These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program. For more information, see the "Well-Being Incentive Programs" that includes the Tobacco Cessation Program in the Healthways Section of this SPD or go to www.BeWellSHBP.com.

SECTION 7 - EXCLUSIONS: WHAT THE CHOICE HMO OPTION MEDICAL PLAN WILL NOT COVER

This section includes services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details*. The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Note: That in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. acupuncture;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. Rolfing (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details*.

Dental

1. dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as identified under *Dental Services - Accident Only* in Section 5, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - extractions (excluding fully impacted wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes (This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 5, *Additional Coverage Details*);
3. dental implants, bone grafts, and other implant-related procedures (This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 5, *Additional Coverage Details*);

4. dental braces (orthodontics);
5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia (This exclusion does not apply to dental care- oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 5, *Additional Coverage Details*);.
6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate; and
7. surgery, appliances or prostheses such as crowns, bridges or dentures; fillings; endodontic care, treatment of dental caries; excision of radicular cysts or granuloma; treatment of periodontal disease; and associated charges with any non-covered dental or oral service or supply; except as noted under Dental Surgery and Oral Care Surgery.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 5, *Additional Coverage Details*. This exclusion does not include diabetic footwear which is covered for a Covered Person with diabetic foot disease. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the- counter.
3. the following items are excluded, even if prescribed by a Physician:
   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - ultrasonic nebulizers;
4. repairs to prosthetic devices due to misuse, malicious damage or gross neglect;
5. replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items;
6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details*;
7. oral appliances for snoring.

Drugs

1. prescription drugs for outpatient use that are filled by a prescription order or refill (see coverage under a separate prescription drug plan administered by Express Scripts);
2. self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. growth hormone therapy;
4. non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office; and
5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular

condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.

Foot Care

1. routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details*.
2. nail trimming, cutting, or debriding (removal of dead skin or underlying tissue), with the exception of diabetic foot care.
3. hygienic and preventive maintenance foot care. Examples include:
- cleaning and soaking the feet;
- other services that are performed when there is not a localized illness, Injury or symptom involving the foot; and
- applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. treatment of flat feet;
5. treatment of subluxation of the foot;
6. shoes (unless prescribed by a Physician with a diagnosis of diabetes and unless permanently attached to a covered brace);
7. shoe orthotics(unless prescribed by a Physician with a diagnosis of diabetes and unless permanently attached to a covered brace);
8. shoe inserts (unless prescribed by a Physician with a diagnosis of diabetes and unless permanently attached to a covered brace); and
9. arch supports.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
   - ace bandages;
   - gauze and dressings;
   - adhesive and adhesive remover;
   - diabetic strips, and syringes (this may be covered under a separate prescription drug plan administered by Express Scripts);
   - deodorant;
   - pouch covers;
   - or any other items not listed as covered as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details*;

This exclusion does not apply to:

- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details*;
- compression stockings for which Benefits are provided as described under Durable Medical Equipment in Section 5, Additional Coverage Details;
- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details*.
- ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details*.

2. tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section* 5 *Additional Coverage Details*.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorder - Autism Spectrum Disorder (ASD) Services and/or Substance Use Disorder Services in Section 5, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. health services or supplies that do not meet the definition of a Covered Health Service – see the definition in Section 11, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:
   - Medically Necessary.
   - described as a Covered Health Service in this Plan under Section 4, *Plan Highlig*hts and Section 5, *Additional Coverage Details*.
   - not otherwise excluded in this Plan under Section 8, Exclusions.
3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
7. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
8. learning, motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
9. intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
11. all unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
13. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods);
2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in Section 5, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

- enteral feedings (providing food through a tube placed in the nose, the stomach, or the small intestine) and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), when approved by Personal Health Support. Infant formula available over the counter is always excluded. Enteral feedings are covered when:
  - adequate nutrition cannot be possible by dietary adjustment and/or oral supplements; and
  - the enteral feeding is the sole source of the patient's caloric intake.

  If enteral feedings are approved by Personal Health Support, then all of the related equipment is also covered. If feedings are NOT approved then equipment is NOT covered. Enteral nutrition products that are administered orally and related supplies are not covered.

- minerals or metabolic deficiency formulas (except when approved by Personal Health Support).
- foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
- oral vitamins and minerals;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements; and

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;
4. guest service;
5. supplies, equipment and similar incidentals for personal comfort. Examples include:
   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players;
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides);
6. blepharoplasty (upper or lower eyelid), browplasty, brow lift (except when approved by Personal Health

Support); and
7. sex transformation operations and related services.

Physical Appearance

1. Cosmetic Procedures, as defined in Section 11, *Glossary*, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins (sclerotherapy only covered when medical necessity and subject to approval by Personal Health Support);
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health clubmemberships and programs, spa treatments, and diversion or general motivation;
3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity (except as covered under the SHBP 2016 Bariatric Program);
4. wigs regardless of the reason for the hair loss except for hair loss due to cancer and or chemotherapy, in which case the Plan pays up to a maximum of $750 per Covered Person per lifetime; and
5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;
2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;
4. speech therapy to treat stuttering, stammering, or other articulation disorders;
5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 5, *Additional Coverage Details*;
6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);
8. psychosurgery (lobotomy);
9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological

support, behavior modification techniques and medications to control cravings;

10. chelation therapy, except to treat heavy metal poisoning;
11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;
12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
13. the following treatments for obesity (except as covered under the SHBP 2016 Bariatric Program):
    - non-surgical treatment, even if for morbid obesity, including but not limited to Optifast, Weight Watchers, Jenny Craig, etc. Panniculectomy, abdominoplasty, repair of diastasis recti, tummy tuck, excision of excessive skin and/or subcutaneous tissue, and liposuction;
    - medical and surgical treatment of adult obesity and a diagnosis of morbid obesity including, but not limited to, bariatric surgical procedures, gastric restrictive procedures, gastric bypass procedures, weight reduction surgery and revisions, and lap band adjustments, (unless previously approved by Personal Health Support from 1/1/2016 through 12/31/2016). Refer to Section 5, *Additional Coverage Detail*s (Nutritional Counseling) for Childhood Obesity limitations; and
14. medical and surgical treatment of hyperhidrosis (excessive sweating);
15. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations, or when the services are considered dental in nature; and
16. breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which UnitedHealthcare determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. certain other health care provider types not covered per UnitedHealthcare clinical and reimbursement policies (including but not limited to massage therapists, acupuncturists)
7. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
8. which are self-directed to a free-standing or Hospital-based diagnostic facility;
9. charges for professional services not rendered by the billing provider; and
10. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
    - prior to ordering the service; or
    - after the service is received.

    This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services

required to treat or correct underlying causes of infertility.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
3. in vitro fertilization regardless of the reason for treatment;
4. the reversal of voluntary sterilization;
5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
6. elective surgical, non-surgical or drug induced Pregnancy termination; This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage, or when life of mother is at risk).
7. services provided by a doula (labor aide);
8. parenting, pre-natal or birthing classes;
9. surrogate parenting;
10. infertility monitoring, correction or treatment; and
11. infertility drugs (coverage may be approved for a medical diagnosis not related to infertility treatment if the medical diagnosis meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. UnitedHealthcare must be contacted by your physician to determine coverage).

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 5*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);
3. any solid organ transplant that is performed as a treatment for cancer;
4. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and
5. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 11, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 11, *Glossary;*
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
2. purchase cost and associated fitting charges for eyeglasses or contact lenses (except for eyeglasses or contact lenses (first pair only) within 12 months following cataract surgery);
3. bone anchored hearing aids except when either of the following applies:
   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions. In addition, the Plan does not pay for telephonic/online hearing tests and evaluations;
4. eye exercise or vision therapy;
5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy;
6. telephonic/online hearing test and evaluations are not covered;
7. surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, LASIK and other refractive eye surgery. NOTE: Discount Program offered for laser eye surgery only through United Health Allies (800) 860-8773;
8. diagnosis, treatment or surgical and non-surgical correction of far-sightedness, near-sightedness or astigmatism. Any vision care, including low-vision and other vision aids; and.
9. tinnitis therapy, including sound generators.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes;
4. diagnostic tests that are:
   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
   - that exceed Eligible Expenses or any specified limitation in this SPD;
6. foreign language and sign language services;
7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
8. health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 11, *Glossary*. Covered Health Services are those health services including services, supplies or prescription drugs, which UnitedHealthcare determines to be all of the following:
   - Medically Necessary;
   - described as a Covered Health Service in this Summary Plan Description; and
   - not otherwise excluded in this Summary Plan Description under this Section 7, *Exclusions*. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement 2;
9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non- Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when that are otherwise covered under the Plan when:
    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type;
11. Inpatient therapies such as rehabilitation, rehabilitative therapy or restorative therapy, unless significant improvement is expected within a reasonable and generally predictable period of time following an acute illness;
12. Transitional living programs, day treatment programs related to senior/adult care treatment, assisted living, non-skilled assisted care, nursing homes, personal care homes, extended care facilities, cognitive remediation therapy;
13. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, a Congenital Anomaly, or as mandated by state law for treatment of autism;
14. Any charge for services, supplies or equipment advertised by the provider as free.

SECTION 8 – CLAIMS PROCEDURES

This section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part

Network Benefits (This HMO Option only pays Non-Network benefits for Emergency care)

In general, when you receive Covered Health Services from Network providers, UnitedHealthcare will pay the Network Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance. Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Filing a Claim for Benefits

When you receive Covered Health Services from a Non-Network Provider and benefits are payable as a result of an emergency or express authorization by UnitedHealthcare, you must submit a request for payment of Benefits within 12 months following the month of service (this may also be referred to as the timely filing deadline). No benefits will be paid for any claim filed after this deadline. If you do not submit this information within the specified time limit the claim will not be paid. Claim forms may be obtained from www.myuhc.com or by contacting Member Services.

Network Providers are subject to contractual timely filing limitations.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the number on your ID card or contacting the Benefits Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address.
- the patient's name, age and relationship to the Participant.
- the number as shown on your ID card.
- the name, address and tax identification number of the provider of the service(s).
- a diagnosis from the Physician.
- the date of service.
- an itemized bill from the provider that includes:
  - -the Current Procedural Terminology (CPT) codes.
  - -a description of, and the charge for, each service.
  - -the date the Sickness or Injury began.
  - -a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you. This information should be filed with UnitedHealthcare, at the address on your ID card. After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non- Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non- Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to Refund of Overpayments in Section 10, *Coordination of Benefits*.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to- understand terms. If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 11, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the

phone, you have the right to file a formal appeal as described in this section.

If a request for Plan benefits is denied, either totally or partially, you or your dependents will receive a notice of denial either electronically or in writing – or, in case of Urgent Care, notice is verbal and then followed by an electronic or written notification.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Member Services before requesting a formal appeal. If the Member Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in this Section 8 *Claims Procedures*, you may appeal it as described below, without first informally contacting Member Services. If you first informally contact Member Services and later wish to request a formal appeal in writing, you should contact Member Services and request an appeal. If you request a formal appeal, a Member Services representative will provide you with the appropriate address of UnitedHealthcare.

If you are appealing an urgent care claim denial, please refer to the table entitled, "Urgent Care Request for Benefits" below and contact Member Services immediately.

How to Appeal a Medical Determination

UnitedHealthcare is the Medical Claim Administrator for the Plan and has sole responsibility and authority to pay medical claims in accordance with the Plan documents, as UnitedHealthcare interprets the Plan documents.

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Note: UnitedHealthcare's decisions are based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing.

This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.

- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, as defined in Section 8, *Claims Procedures, Timing of Appeals Determinations*, the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined in Section 8, *Claims Procedures, Timing of Appeals Determinations*, the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "*Urgent Claim Appeals that Require Immediate Action* and *Timing of Appeals Determination*".

If you are not satisfied with the first level appeal decision of UnitedHealthcare, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted to UnitedHealthcare in writing within 60 days from receipt of the first level appeal decision.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

For all medical claim appeals, including pre-service and post-service claim appeals, United Healthcare has the exclusive right to interpret and administer the provisions of the Plan. UnitedHealthcare's decisions are conclusive and binding.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your Physician should call UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.

For all medical claim appeals, including urgent claim appeals, UnitedHealthcare has the exclusive right to interpret and administer the provisions of the Plan.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit

in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available

expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- urgent care request for Benefits - a request for Benefits provided in connection with urgent care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that UnitedHealthcare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in UnitedHealthcare's decision letter to you.

The following tables describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
If the initial request for Benefits is complete, within:	**15 days**
After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
If the initial claim is complete, within:	**30 days**
After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Georgia Department of Community Health or UnitedHealthcare to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Georgia Department of Community Health or UnitedHealthcare, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Georgia Department of Community Health or UnitedHealthcare.

You cannot bring any legal action against Georgia Department of Community Health or UnitedHealthcare for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Georgia Department of Community Health or UnitedHealthcare you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Georgia Department of Community Health or UnitedHealthcare

SECTION 9 - COORDINATION OF BENEFITS (COB)

This section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare;
- Order of payment rules; and
- Procedures in the event the Plan overpays Benefits.

Filing a Claim When Coordination of Benefits (COB) applies

You and your covered Dependents may have medical coverage under more than one non-Medicare Advantage (MA) plan. In this case, the Plans coordination of benefits (COB) provisions apply.

When the SHBP is secondary, benefits are coordinated utilizing the non-duplication rule. Non-duplication maintains the Covered Person's same benefit level, regardless of the existence of two carriers. The Plan pays only the difference between the plan's normal benefit and any amount payable by the primary plan. The Covered Person is responsible for any remaining balance including Copayments. If this Plan is secondary, the allowable expense is the primary carrier's contracted rate. If the primary plan bases its reimbursement on reasonable and customary charges, the patient's liability is up to the primary carrier's reasonable and customary amount. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary and the patient's liability is up to the greater of the two carriers' reasonable & customary calculated on a line-by-line basis.

Non-Covered Services or items, penalties, and amounts balance billed are not part of the allowed amount and are the Covered Person's responsibility.

- COB applies to group health coverage, including:
  - Government programs such as Medicare or state contracts (dual SHBP coverage)
  - Your spouse's insurance at his or her work
  - COBRA coverage
- COB does not apply to an individual policy – one for which you pay the total premium directly to the insurer.

If the 12-month timely filing limit is approaching and you have not received an explanation of benefits (EOB) from the primary plan, submit your claim(s) to the Plan without the EOB prior to the deadline. When you receive the EOB, send it to the Plan for processing, even if the deadline has passed.

For COB information that applies when you or a covered dependent is injured in an accident caused by another party, see Section 10, *Subrogation and Reimbursement*.

How COB Works

- When you or your Dependents are covered by two group health plans, determine which plan is the primary and which is secondary. The primary plan is obligated to pay a claim first, which generally means that it will pay most of the expenses.
- Submit claims to the primary plan first. You will receive a benefit payment from that plan along with an explanation of benefits (EOB).
- Make a copy of the EOB you received from the primary plan, attach it to a claim form and mail both to the secondary plan. The SHBP won't pay a secondary benefit until you submit the primary plan's EOB. Indicate the name and policy number of the person who has the other coverage and that plan's group number.

If your other group coverage ends, you must report the cancellation date to SHBP Member Services in writing and include supporting documentation from the primary plan. You can get the information from your employer or from the other insurance company.

How to Tell Which Plan is Primary

Generally, a plan is primary when:

- The patient is the Covered Person or employee
- The plan does not have coordination of benefits
- The plan is a Workman's Compensation Plan or an automobile insurance medical benefit
- The other plan is Medicare and the patient is covered under the group plan of an active employee. Note: Covered Persons under the age 65 may qualify for Medicare because of a covered disability or end-stage renal disease. SHBP coverage will be primary until the Medicare waiting period has been exhausted. Medicare determines the length of time the SHBP coverage is primary.

In other situations, determining which plan is primary is more complicated:

- **If the patient is a dependent child with married parents**, the plan that covers the parent whose birthday comes first in the Calendar year is primary, unless the parents are divorced. If both parents were born on the same date, the plan that has covered the parent for the longest time pays first.
- **When a plan uses the gender rule to determine the primary plan**, the father's plan is primary. If the other plan follows the gender rule, the SHBP will allow the father's plan to be primary.
- **When the patient is a dependent child whose parents are divorced**, the plan of the parent with custody pays first, except where a court decrees otherwise.
- **If the parent with legal custody has remarried:**
  - The plan of the parent with legal custody pays first.
  - The plan of the spouse of the parent with custody pays second.
  - The plan of the parent who does not have custody pays last.

If custody is joint, the plan that covers the parent whose birthday comes first in the Calendar Year is primary.

- **When two plans cover the Covered Person as an active employee**, the plan that has covered the employee the longest pays first.
- **For active employees versus inactive employees, a plan that covers a person:**
  - As an active employee is primary over a plan that covers a person who is retired, laid off or covered under COBRA.
  - As an inactive employee is primary over a plan that covers the inactive employee as the spouse of an active employee.
  - As a dependent of an active employee is primary over Medicare coverage for a retiree.

If none of the rules described in this section apply, the plan that has covered the person the longest is primary.

If You Have Dual Plan Coverage

Coordination of benefits when both you and your spouse have Plan coverage as Covered Person (i.e., when you have dual coverage) works like this:

- If one of you has family coverage and the other has single coverage, only the spouse with the single coverage has dual coverage.
- When both spouses have dual coverage, the coverage of the spouse who is the patient is primary.
- If the patient is a dependent, then the plan that covers the parent whose birthday comes first in the Calendar year is primary.

When you have dual coverage, you cannot transfer Deductibles between Plan contracts.

Note: You cannot have dual coverage with Medicare Advantage. CMS will only allow enrollment in one MA plan. If you enroll in more than one MA plan, the last plan enrolled in will terminate the current enrollment. If the terminated MA plan is with SHBP the termination will end your SHBP coverage.

Other Forms of Duplicated Benefits

- The Plan does not duplicate payments that you may receive under third-party medical payment contracts or because of any lawsuit, including malpractice litigation.
- If you receive medical payments from underwriters of a homeowner's policy, an automobile insurance policy or any other payment plan, the Plan will consider only those charges over the amounts paid by the third party(ies).
- The Plan has the right to delay your payments until it determines whether or not other parties are liable for paying your medical expenses. However, when the employee or Covered Dependent must sue to determine the parties' obligations, the Plan will not delay payment provided that you or the payee agrees to reimburse the Plan for duplicated medical payments.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to UnitedHealthcare to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to UnitedHealthcare. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with UnitedHealthcare.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan.

The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no- fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for

damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan;
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 – GLOSSARY

This section includes Definitions of terms used throughout this SPD. Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Autism Spectrum Disorders (ASD) - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Georgia Department of Community Health. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide medical claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance - the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);

- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Copayment (or Copay) - the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:
- Medically Necessary;
- included in Sections 4 and 5, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described the Eligibility and Enrollment Provisions booklet that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.dch.georgia.gov/shbp-plan-documents; and
- not identified in Section 7, *Exclusions*.

Covered Person - either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person. Covered Person means a person who meets all eligibility requirements for the Plan as a result of his or her current or former employment, who is currently enrolled in coverage and who has paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that do not require special skills or training and that:
- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the Eligibility and Enrollment Provisions booklet that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.dch.georgia.gov/shbp-plan-documents. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Facility - a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Durable Medical Equipment (DME) - medical equipment that is all of the following:
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;

- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee - a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described in the Eligibility and Enrollment Provisions booklet that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.dch.georgia.gov/shbp-plan-documents. An Employee must live and/or work in the United States.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 5, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance- related and addictive disorders treatment program that may be free-standing or Hospital- based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Georgia Department of Community Health. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and

improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Medical Claims Administrator's sole discretion.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services.

These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on ww.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.unitedhealthcareonline.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the **(UnitedHealthcare)** organization or individual who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions*.

Network Provider - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with UnitedHealthcare or with UnitedHealthcare's affiliate to participate in UnitedHealthcare's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health

Services, or to be a Network provider for only some of UnitedHealthcare's products. In this case, the provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network Provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights* for details about how Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician as long as the provider type is not otherwise excluded from coverage. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The State Health Benefit Plan.

Plan Administrator - Georgia Department of Community Health, SHBP Division.

Plan Sponsor - Georgia Department of Community Health.

Pregnancy - includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Preventive Care or Preventive Services – For details on Preventive Care Services covered under applicable law visit the Healthcare.gov website at https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults/. Another option to view Preventive Care Services specific to age and gender is to visit the UnitedHealthcare preventive care website at http://uhcpreventivecare.com/.

Services provided during a wellness exam must be coded as preventive care services by your Provider in order to be considered preventive care. You should discuss with your Provider before your appointment how he or she will code your treatment.

In summary, preventive care services provided in an outpatient setting by health care professionals (Physicians, Alternative Facility, and Hospitals) are medical services proven to have beneficial health outcomes and to be safe and effective in early disease detection or disease prevention. Under applicable laws, preventive care services require evidence-based medicine;

services rated " A" or " B " by the United States Preventive Services Task Force; Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention immunization recommendations; and Health Resources and Services Administration supported evidence-informed preventive care and screenings.

Certain medical services can be done for preventive or diagnostic reasons. In general, preventive services are those performed on a person who:

- has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or
- has had screening done within the recommended interval with the findings considered normal; or
- has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals; or
- has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

Examples of services that are NOT considered Preventive Care
These services are not considered preventive. Please see the Sections entitled, *Physician Office Services or the Outpatient Surgery, Diagnostic and Therapeutic Services* of your Summary Plan Description for benefits.

NOTE: This list is not all-inclusive.

- chest x-ray;
- electrocardiogram (EKG, ECG;)
- cardiac stress test;
- MRI's & CT Scans;
- routine eye examinations;
- hearing tests for adults; and
- follow up mammograms and Pap smears when problems are detected.

Primary Care Physician - Primary Care Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Prior Authorization – Prior Authorization determines benefit coverage, based on Medical Necessity criteria, for services, tests, or procedures that are safe, appropriate and cost-effective for the individual member. This patient-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital. See the *Exclusions* Section of this SPD.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by SHBP and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

SHBP – State Health Benefit Plan. The State Health Benefit Plan is comprised of three health insurance plans established by Georgia law: 1) a plan for State employees (O.C.G.A. § 45-18-2), 2) a plan for teachers (O.C.G.A. § 20-2-891), and 3) a plan for non-certificated public school employees (O.C.G.A. § 20-2-911). Currently, benefit options are the same under all three plans and they are usually referred to together as the State Health Benefit Plan. This HDHP Option is an option under the State Health Benefit Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi- private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare may use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses for Covered Health Services. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 4, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:
- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Transition of Care -Transition of care is a service that enables new enrollees to receive time limited care for specified medical conditions from an Out-of-Network physician, as expressly approved by UnitedHealthcare, at the benefit level associated with Network physicians.

Transitional Care - Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ - a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions. To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Note: If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is

sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 12 - IMPORTANT ADMINISTRATIVE INFORMATION

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Medical Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

UnitedHealthcare shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. **UnitedHealthcare shall not be responsible for fulfilling any duties or obligations** of an employer with respect to the Plan Sponsor's Plan.

Note: Pharmacy and Wellness benefits are administered separately. Express Scripts provides administrative pharmacy claims payment services. Healthways, Inc. is the Well-Being program administrator.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential. UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish UnitedHealthcare with all information or copies of records relating to the services provided to you. UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. UnitedHealthcare agrees that such information and records will be considered confidential.

UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Georgia Department of Community Health is required to do by law or regulation. During and after the term of the Plan, Georgia Department of Community Health and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Covered Person's Rights and Responsibilities

Your Rights as a Covered Person Enrolled in Plan Coverage.

You have the right to:

- Have your eligible claims paid and notifications provided in a timely manner.
- Receive information about the Plan and the options available to you.
- Be informed of the process for filing appeals of denied claims.
- Have access to Provider information.
- Review your appeal file.
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office.
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply).
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations.
- Take the time to understand how this Plan option works. You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the SHBP Decision Guide. Having read the documents, you can take steps to maximize your coverage.
- Notify SHBP Member Services if you or any of your dependents are no longer eligible for coverage.
- Notify SHBP Member Services of any address change and read all information sent to you by Georgia Department of Community Health, SHBP Division. You are responsible for reading any information SHBP or UnitedHealthcare send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf.
- Notify the SHBP Member Services of any other group coverage you have, including Medicare coverage. You may be required to provide notification in advance or on request.

SECTION 13 – UNITEDHEALTH ALLIES

UnitedHealth Allies provides discounts for select non-Covered Health Services from Physicians and health care professionals. UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 4, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan. Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 11, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important**:** You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

End of Medical Claims Administrator Section

WELLNESS PROGRAM ADMINISTRATOR

Well-Being Program - Be Well SHBP

Well-Being Program Description – Be Well SHBP

State Health Benefit Plan will continue to sponsor Well-Being Programs through a Wellness Program Administrator, Healthways. The Healthways team will provide you with the support, tools and lifestyle management information you need to improve your own health and well-being.

Note: Regardless of the Plan Option you select (excluding TRICARE Supplement), all unused well-being incentive credits earned while participating in SHBP's 2015 wellness program will now rollover if you remain enrolled in your current Plan Option and vendor or change to another Plan Option and/or vendor during Open Enrollment (OE). Please see the section entitled "Well-Being Incentive Credit Rollover Between Plan Options and Vendors".

Well-Being Incentive Credits

In 2016, you and your covered spouse are each eligible to receive a well-being reward of up to 480 well-being incentive credits when you are enrolled in UnitedHealthcare and complete the activities below between January 1, 2016 and December 15, 2016. That is a family total of 960 well-being incentive credits.

	What To Do	What You Earn
1.	**ASSESS YOUR HEALTH** Complete your 2016 Healthways Well-Being Assessment® (WBA), a confidential, online questionnaire that will take about 20 minutes.	**Complete** BOTH **and earn 240** well-being incentive credits. (*WBA must be completed before any incentive can be earned*)
2.	**KNOW YOUR NUMBERS** Complete a 2016 biometric screening and submit results (body mass index, blood pressure, cholesterol, glucose). The biometric screening must be completed at an SHBP sponsored biometric screening event or by your physician and your results submitted appropriately on the 2016 Physician Screening Form.	
3.	**TAKE ACTION** It's your choice! Complete the coaching or online pathway, or a combination of both. **COACHING PATHWAY** Complete your WBA and Actively engage in telephonic coaching. **ONLINE PATHWAY** Create your WBA and Record five online well-being activities using the same tracker within a calendar month and earn 40 well-being incentive credits. You can earn these rewards up to six times. A sample online activity would be to track your daily steps five times within a calendar month.	**Earn up to 240** well-being incentive credits. (*WBA must be completed before any incentive can be earned*)

Getting Started
To get started log onto www.BeWellSHBP.com and click "Take Your Well-Being Assessment". You will be asked to enter your five registration credentials of First Name, Last Name, Date of Birth, Gender and Zip Code. Your name should be entered exactly as it appears on your Member ID card. Upon registration you will be prompted to take your Well-Being Assessment (WBA).

Note: You cannot continue on the site without completing your Well-Being Assessment and creating your Well-Being Plan.

Well-being Incentive Credit Rollover Between Plan Options and Vendors
All unused well-being incentive credits earned while participating in the Healthways Well-Being Program called Be Well SHBP will now rollover whether you remain enrolled in your current Plan Option and medical claims administrator or change to another Plan Option and/or medical claims administrator during Open Enrollment (OE).

This means no matter what Plan Option you select (excluding TRICARE Supplement), you will not forfeit any unused well-being incentive credits you have earned.

Note: Unused well-being incentive credits will rollover in April of 2016. This allows 2015 Well-being Incentive credits to be used to pay your out-of-pocket expenses for 2015 claims filed after December 31, 2015. There is a date limitation to how you may use the 2015 rollover credits for reimbursement. Only eligible medical expenses incurred after the rollover in April 2016 will qualify for reimbursement using the 2015 well-being incentive credit rollover funds. Expenses for services incurred between January – March 2016 are not eligible for reimbursement from 2015 rollover credits. However, until your 2015 credits roll over, your 2016 well-being incentive credits earned and available at the time claims are received by your medical claims administrator may be used for those expenses during this time period.

Healthways Well-Being Services

The SHBP web portal,www.BeWellSHBP.com, provides a link to Healthways Well-Being Connect portal. Well-Being Connect is a web-based application geared to help eligible Members establish and consistently engage in healthy behaviors through personal Well-Being Plans and helpful tools.

Key components of Well-Being Connect include:

- **Live Chat:** Enables Members to directly outreach to a coach or Member services staff.
- **Well-Being Plan:** The Well-Being Plan helps you reach your healthy best. Your answers to the Healthways Well-Being Assessment® (WBA) help gauge the focus areas you're most ready to act on and shape your personal Well-Being Plan.
- **Mobile Application and Smart Phone Technology:** Well-Being Connect mobile app places the power of Well-Being Connect in the hands of smartphone users.
- **Health Trackers**: for medication adherence, exercise, healthy eating, personal tracker (allows Members to create their own tracker), steps program, tobacco cessation, and weight management.
- **Online Campaigns and Challenges:** The Groups and Challenges feature allows Members to interact with one another, or compete against one another in pre-defined challenges for walking (steps program), exercise, and weight loss.
- **Educational Tools and Information:** The portal pushes health information, articles and video segments to Members based on their Well-Being Plan, progress toward behavior change, and specified preferences. There is also a portal library that includes hundreds of articles on health and disease topics, healthy recipes, and meal plans.
- **Device integration to promote fitness, exercise and health and Well-Being:** Members using **Well-Being Connect** can link their own devices, such as a 'Fitbit Ultra' pedometer or 'Withings wi-fi scale,' to the trackers in their personal plans. Once linked, the device will share its data with Well-Being Connect automatically, updating activity trackers. When a participant logs into Well-Being Connect, the data will populate from the device vendor (i.e., Fitbit) and use it to update the appropriate data points in your Well-Being Plan. Neither Healthways nor SHBP can assist with the use of the devices. Members are responsible for making sure that the information is properly tracked.
- **Well-Being Incentive Credits and Rewards Tracking:** The portal supports direct incentive tracking and shows real-time awards accumulation for the Member and spouse if covered. This tracker allows Members to see their incentive progress.

Healthways Well-Being Assessment®

The Healthways Well-Being Assessment® (WBA) is a confidential health questionnaire that assesses your lifestyle and overall health. Simply answer a few questions and get instant feedback on what's helping or hurting your overall health and Well-Being.

The Well-Being report is a personalized summary of overall Well-Being, from your Well-Being Assessment results, that offers insight into actionable steps you can take to improve your health. To begin the process, please visit www.BeWellSHBP.com.

Biometric Screenings

A Biometric Screening provides an excellent opportunity to know your biometric numbers and what they mean for you. The screening typically takes 10-15 minutes. During a biometric screening event, a health professional will collect measurements, including body mass index (BMI), blood pressure, cholesterol and glucose. In 2016, SHBP Members and covered spouses will have the opportunity to obtain a biometric screening at their personal Physician's office or at a SHBP-sponsored biometric screening event. For information on biometric screenings please visit www.BeWellSHBP.com or call us at 888-616-6411.

2016 Physician Screening Forms

You may complete your screening with your Physician and utilize an easy-to-use 2016 Physician Screening Form. The form can be accessed through the www.BeWellSHBP.com microsite, printed from your computer and taken to your Physician for completion. Each individual will need to log in and enter their first and last name as it appears on their Member ID card, date of birth, zip code and gender to pre-populate the form. Any 2016 Physician Screening Forms not pre-populated will not be processed. The 2016 Physician Screening Form processing oversight is handled by Healthways.

If the 2016 Physician Screening Form submitted by your Physician is incomplete (i.e., missing pre- populated Member information, missing Physician signature or participant signature), your form will not be processed. In order to process your form and have your results loaded into the portal, you will need to work with your Physician's office to ensure that the form is signed and submitted by the deadline of December 15, 2016. If your form is signed, but only partially completed, your form will be processed as is and the portal will only show results for the data provided. Well-being incentive credits will only be awarded when all of the results are complete. For information on Physician Screening Forms, please visit www.BeWellSHBP.com or call 888-616-6411.

Telephonic Well-Being Coaching

Telephonic coaching is designed to help you address identified risks factors and to create a plan to reduce risks and improve your overall health. Areas of risk that coaching can support include: depression prevention, exercise, healthy eating, stress management, tobacco cessation and weight management, as well as other risk areas.

Well-Being Coaches maintain confidentiality and work to establish attainable goals collaboratively with you. Telephonic coaching utilizes many features of the Be Well SHBP portal, including integrating your Well-Being Plan. Your coach will have confidential access to your Well-Being Plan, including your Well-Being Assessment and biometric data, and will be able to see your progress towards your goals. Well-Being Coaching support is provided as long as you need it. Additionally, you can make unlimited in-bound calls for ongoing support as needed.

Individuals identified for coaching will be directly contacted to enroll in the Well-Being Coaching program. Individuals not identified for coaching support may self-enroll by calling 888-616-6411.

Family Centered Well-Being

The Be Well SHBP program includes an adolescent module entitled, "Health in Motion". Health in Motion is a self-directed, evidence-based online module that addresses multiple behaviors for preventing obesity through a personalized, science-based, and efficient approach. Log onto www.BeWellSHBP.com and learn more.

Well-Being Incentive Tracking

Through the Well-Being Connect portal, Members can see up to date statuses regarding well-being incentive credits. The well-being incentive credits will be available the month after completion of the activity. This includes completion of the Well-Being Assessment and biometric screening, enrollment and engagement in Well-Being Coaching, and ongoing participation in the Well-Being Connect portal.

To view your rewards in real-time you must register at www.BeWellSHBP.com. Members have the ability to print their incentive status in the Reward Center of the portal. The Rewards Center also provides Member incentive status and date of award in real-time. Members can perform a print-page function to show evidence they completed the required activities for program completion.

Timelines for Actions to be Posted

The Healthways Well-Being Assessment® will be live on January 1, 2016. Immediately after taking the

Well-Being Assessment® you will receive your Well-Being Assessment Report. Within 24 hours you will be invited back to the site to register and set up your Well-Being Plan, if you do not already have one. You have until December 15, 2016 to complete your Well-Being Assessment®.

The 2016 action-based incentive credits will be earned as the action is completed and will be available in your incentive account within 30 days. After completion of the Well-Being Assessment, if you complete a Telephonic Well-Being Coaching engagement call and an advising coaching call or if you complete two Telephonic Well-Being Coaching advising calls you will be awarded a total of 240 well-being incentive credits.

When the biometric screening is completed at a 2016 SHBP-sponsored biometric screening event or by your Physician in 2016 and the data is successfully completed as outlined within all documents, you will earn 240 well-being incentive credits if you also completed your Well-Being Assessment at www.BeWellSHBP.com.

If your well-being incentive credits are not properly displaying in the www.BeWellSHBP.com Reward Center portal, please call Healthways at 888-616-6411.

2016 Well-Being Incentive Credits Appeal Process

If you or your covered Spouse, or both, are advised that your 2016 Well-Being Incentive Credits were not obtained, you may appeal this decision directly to Healthways. Appeals, along with the requested documents, must be submitted by 5:00 pm, EDT **January 31, 2017.** Well-Being Incentive Credits Appeals submitted after this date will be denied.

Level I – Well-Being Incentive Credits Appeals

To file a Well-Being Incentive Credits Appeal, complete all applicable sections on the Level 1 - 2016 Well-Being Incentive Credits Appeal Form located at www.BeWellSHBP.com/appeals/, sign and date the form. If the 2016 Well-Being Activity in question was not satisfied due to circumstances beyond your control, you should explain why in the space provided on the Level 1 - 2016 Well-Being Incentive Credits Appeal Form. Examples of "circumstances beyond your control" include, but are not limited to, the following: incarceration, long term hospital stay, and hospice stay.

You should submit the form, along with the supporting documentation, to the email, fax or mailing address located on the Level 1 - 2016 Well-Being Incentive Credits Appeal Form. An example of appropriate supporting documentation includes:

- A copy of the completed 2016 Physician Screening Form (if applicable).
- A copy of completed screening consent form containing results as proof of onsite screening participation upon completion at a SHBP sponsored event
- When the online Well-Being Assessment® through BeWellSHBP.com is complete, print a copy of the report.
- When activities through the coaching or online pathway are complete, print screen the rewards balance page.

Level II – Formal Appeal

If your 2016 Well-Being Incentive Credits Appeal is denied, you may file a Formal Appeal, which must be postmarked within 15 calendar days following the date of the 2016 Level 1 Well-Being Incentive Credits Appeal decision. To file a Formal Appeal, you must complete the Level 2 – 2016 Well-Being Incentive Credits Appeal Form and attach a copy of the 2016 Level 1 Appeal decision, along with any supporting documentation. The Level 2 - 2016 Well-Being Incentive Credits Appeal form is located at www.BeWellSHBP.com/appeals/. Instructions are included on the form.

Generally, a decision by the Formal Appeal committee will be issued within 30 thirty (30) calendar days following receipt. The written notice of the decision by the Committee is the final step in the administrative proceedings and will exhaust all administrative remedies.

Please forward all written requests for Formal Appeals along with a completed Level 2 2016 Well-Being Incentive Credits Appeal Form to the email, fax or mailing address located on the Appeal Form. The appeal form is available at www.BeWellSHBP.com/appeals/.

Tobacco Cessation

Tobacco Cessation Telephonic Well-Being Coaching

Resources for quitting tobacco that are available to eligible Members, covered spouses and dependents 18 years and older:

- Access to QuitNet® online network to those who have quit or are quitting
- Phone coaching sessions with a trained counselor
- E-mail tips offering motivation and encouragement
- Access to Nicotine Replacement Therapy coverage – see Pharmacy Claims Administrator section
- Tobacco Cessation Well-Being Plans
- Self-refer into coaching or online support via the Well-Being Connect or Quitnet.com at any time.

Individuals identified for tobacco coaching will be directly contacted to enroll in the coaching program. Individuals not identified for coaching support may self-enroll by calling 888-616-6411.

Tobacco Surcharge

Tobacco surcharges are included in all SHBP Options (other than Medicare Advantage Options). These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program.

Go to www.dch.georgia.gov/shbp-plan-documents to access the tobacco surcharge removal policies and forms. These policies allow you to have the tobacco surcharge removed by completing the tobacco surcharge removal requirements through Healthways.

If you and your enrolled Dependents who use tobacco complete the telephonic or online tobacco cessation Well-Being Coaching program and the well-being assessment, you will be able to avoid the tobacco surcharge for the entire year. This means that any surcharge paid in 2016 may be refunded after the completion of the tobacco surcharge removal requirements. The tobacco surcharge removal requirements must all be completed in 2016. Contact Healthways at 888-616-6411 for more information.

If you think you may be unable to complete the tobacco surcharge removal requirements, you may qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Healthways at 888-616-6411 and we will work with you (and, if you wish, with your doctor) to find a well-being program with the same reward that is right for you in light of your health status.

Healthway's Definitions

Health in Motion
Health in Motion is a self-directed, evidence-based online module that addresses multiple behaviors for preventing obesity through a personalized, science-based, and efficient approach.

Healthways Well-Being Assessment®
The Healthways Well-Being Assessment® (WBA) is a confidential health questionnaire that assesses your lifestyle and overall health. Simply answer a few questions and get instant feedback on what's helping or hurting your overall health and well-being.

Member or Covered Member
People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Physician Screening Form
The Physician Screening Form is a form that your physician can complete with biometric results from your wellness visit or annual physical exam.

QuitNet®
Healthways, Inc. tobacco cessation program.

QuitNet.com
Healthways tobacco cessation website.

Well-Being Coaching
Well-Being Coaching helps you find opportunities to improve well-being every day. Through convenient phone-based sessions, Well-Being Coaching guides you through healthy behavior changes by building on your strengths. The program is confidential, voluntary, and offered to you as part of your plan benefits at no additional cost to you. You decide if you want to participate and how involved you want to be. All calls are scheduled at your convenience and on your time line. With help from Well-Being Coaching you can:
•Better understand your health risks
•Get answers to your health questions
•Find support to gain more control over your health
•Set goals to reach your healthy best

Well-Being Connect
Well-Being Connect is a web-based application geared to help eligible Members establish and consistently engage in healthy behaviors through personal Well-Being Plans and helpful tools.

Well-Being Plan
Provides tailored feedback and messaging based on the risk factors and behaviors that are contributing to or subtracting form an individual's overall well-being, and is directly integrated in Healthways' Well-Being Connect online application.

Well-Being Report
A personalized summary of overall Well-Being that offers insight into actionable steps you can take to improve your health.

End of the Wellness Program Administrator Section

PHARMACY CLAIMS ADMINISTRATOR – OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider to the Summary Plan Description (SPD) provides Benefits for outpatient Prescription Drug Products. Express Scripts administers your Prescription Drug Pharmacy Benefits.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy, Express Scripts Home Delivery, Accredo (an Express Scripts Specialty pharmacy), or an out- of-network pharmacy.

Because this Rider is part of a legal document, we want to give you information about this document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Express Scripts Pharmacy Definition Section.

When we use the words "we," "us" and "our" in this document, we are referring to Department of Community Health (DCH), State Health Benefit Plan (SHBP) Division. When we use the words "you" and "your," we are referring to people who are Covered Members.

Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described in Section "What's Covered- Prescription Drug Benefits".

Benefits for Outpatient Prescription Drug Products

This Rider will cover a detailed description about your prescription drug plan benefit supply limits; prior authorizations (PA); maintenance medications; covered medications; non-covered medications; definitions of Generic and Brand-name medications; and the step therapy program.

Benefits are available for outpatient Prescription Drug Products on the Express Scripts prescription drug list, which meet the definition of a covered health service and are dispensed at a licensed pharmacy. Copayments (Copay) or other payments you are responsible for will vary depending on the outpatient Prescription Drug Product's placement within the three (3) tiers of the Express Scripts Prescription Drug List. See the Prescription Drug Pharmacy Benefits Copayment table in the "Schedule of Benefits" in this Section.

Payment Information

Copayment for a Prescription Drug Product at a Network Pharmacy is a flat dollar amount. Your Copayment is based on which tier the drug falls into and is determined by Express Scripts, the Pharmacy Claims Administrator. Copayment amounts will not be overridden or changed on an individual basis.

Note: Copayment amounts do not go toward the deductible; however, they do go toward the Out-of-Pocket Maximum.

Choice HMO Plan	
Prescription Drug Pharmacy Benefits **Copayments you must pay**	
31-day supply for a participating Retail Network Pharmacy	
Tier 1 Copayment Generic	$20 for up to 31-day supply
Tier 2 Copayment (preferred) Brand	$50 for up to 31-day supply
Tier 3 Copayment (non-preferred) Brand	$90 for up to 31-day supply
90-day Supply for maintenance drugs from mail order **OR at participating 90-Day Retail Network Pharmacies**	
Tier 1: 2½ x the monthly Copayment	$50 for up to a 90-day supply
Tier 2: 2½ x the monthly Copayment	$125 for up to a 90-day supply
Tier 3: 2½ x the monthly Copayment	$225 for up to a 90-day supply
90-day Supply for maintenance drugs from a Retail Network Pharmacy **which is not part of the 90-Day Retail Network Pharmacies**	
Tier 1: 3 x the monthly Copayment	$60 for up to a 90-day supply
Tier 2: 3 x the monthly Copayment	$150 for up to a 90-day supply
Tier 3: 3 x the monthly Copayment	$270 for up to a 90-day supply
Copayment for a Prescription Drug Product at a Network Pharmacy is a flat dollar amount. Your Copayment is based on the applicable drug tier. Copayments will not be overridden or changed on an individual basis. If a generic product is available and you choose to use the branded product instead, then you will pay the applicable generic Copayment plus the cost difference between the generic product and its brand product. **Note:** Prescription Copayments do not apply to the Deductible. Prescription Copayments do apply to your Out-of-Pocket Maximum.	

For Prescription Drug Products at a participating Retail Network Pharmacy, you are responsible for paying:

- The applicable Copayment; or
- The applicable Copayment and Ancillary Charge; or
- The Network Pharmacy Usual and Customary Charge, which includes a dispensing fee and may include sales tax for the Prescription Drug Product if this results in a lower price than the applicable Copayment.

For Prescription Drug Products from the Express Scripts Pharmacy Home Delivery Service or Accredo, an Express Scripts Specialty Pharmacy, you are responsible for paying:

- The applicable Copayment; or
- The applicable Copayment and Ancillary Charge; or
- The Prescription Drug Cost for that Prescription Drug Product if this results in a lower price than the applicable Copayment.

Note: For the most up-to-date coverage information (including supply limits, PA requirements, etc.) for Prescription Drug Products that meet the definition of a Covered Health Service, call Express Scripts Member Services number on your Member ID card or at visit Express-Scripts.com/GeorgiaSHBP.

Coverage Policies and Guidelines

Your Express Scripts pharmacy benefit provides coverage for a comprehensive selection of Prescription medications. The most commonly prescribed medications for certain conditions are named or described in the 2016 Express Scripts National Preferred Formulary (Preferred Drug List/PDL). All Covered Outpatient Prescription Drug Products on the PDL are FDA-approved Prescription Drug Products.

The PDL places commonly prescribed medications for certain conditions into tiers.

Your HMO Plan will have Prescription Medications Placed in Tiers.

Prescription medications are categorized within three (3) tiers which are determined by the Pharmacy Administrator. Each tier is assigned a Copayment amount which is determined by the Plan. Please consult the Express Scripts National Preferred Drug List at Express-Scripts.com/GeorgiaSHBP, or call the Express Scripts member services number on your Member ID card for the most up-to-date tier status of your medication(s). When you fill a prescription, you pay the Copayment at the time the prescription is filled.

Several factors are considered when deciding the placement of a medication on the Express Scripts prescription drug list.

The Express Scripts National Pharmacy and Therapeutics Committee (P&T Committee) evaluates clinical evidence in order to determine a medication's role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficiency of the medication.

The Express Scripts National P&T Committee evaluates the clinical recommendations of the Therapeutic Assessment Committee as well as pharmacoeconomic and economic information provided by the Value Assessment Committee. Once a medication's clinical, pharmacoeconomic and economic value is established, the P&T Committee makes a tier placement decision based on the overall value of the medication. The P&T Committee helps to ensure access to a wide range of affordable medications for you.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Member is a determination that is made between the Member and their prescribing physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay Copayment and other payments, as set forth on the most current Express Scripts prescription drug list. Tier status and Copayment will not be overridden or changed.

Member Identification Card (Member ID card) – Network Pharmacy

In order to utilize your Prescription Drug Benefit at a participating Retail Network Pharmacy, you should show your Member ID card at the time you obtain your prescription drug medication at a participating Retail Network Pharmacy.

If you do not show your Member ID card at a Network Pharmacy, you will be required to pay the Full Retail Cost (Usual and Customary Charge) for the Prescription Drug Product at the pharmacy.

If you paid full Retail Cost at the pharmacy and wish to seek reimbursement, you may obtain a prescription drug claim form by calling Express Scripts Member Services on your UnitedHealthcare ID card. Along with the prescription drug claim form, you will need the pharmacy receipt for your prescription.

You must submit a request for payment of benefits within twelve (12) months following the date of service (also be referred to as the timely filing deadline). If you do not submit this information within the specified time limit, the claim will not be paid.

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when purchasing the Prescription Drug Product. The amount you are reimbursed will be based on the approved prescription drug cost, less the required Copayment and any other applicable charges.

Accredo, an Express Scripts Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether the drugs are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service.

Drugs which have been identified as Specialty Prescription Drugs for your benefit plan are listed on the Express Scripts website Express-Scripts.com/GeorgiaSHBP. Your prescriptions must be filled through Accredo's home delivery program if you have a prescription for one of these products. See "Glossary and Definitions" for definitions of Specialty Prescription Drug Product and Designated Pharmacy. See "What's Covered- Prescription Drug Benefits" Section for more information on Specialty Prescription Drug Product.

Note: Most Specialty drug prescriptions are allowed at least the first fill at a participating network retail pharmacy; however, there are some exceptions. To find out if you are allowed one retail pharmacy fill for your particular specialty drug, contact Express Scripts at the number on your card. If you use any pharmacy other than Accredo after the number of allowed retail fills, you will be subject to the entire cost of the medication.

Limitation on Selection of Pharmacies

If Express Scripts determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, Express Scripts selects your most recently used Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy.

Member Rights and Responsibilities

As a member, you have the right to express concerns about your SHBP coverage and to expect an unbiased

resolution of your individual issues. You have the right to submit a written appeal or inquiry regarding any concern that you may have about the prescription drug program or your drug coverage.

Express Scripts Member Services

Written appeals and inquiries related to the prescription drug program should be directed to:

Express Scripts Appeals Department
State of Georgia Health Benefit Plan Members
P.O. Box 66588
St. Louis, MO 63166-6588

Prescription Drug Disclaimer

This SPD summarizes the State Health Benefit Plan Prescription Drug Program. It is not intended to cover all details related to your prescription drug coverage under the SHBP. This SPD is not a contract and the Benefits that are described can be terminated or amended by the Plan Administrator according to applicable laws, rules and regulations. If there are discrepancies between the information in this booklet and DCH Board regulations or the laws of the state of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

What Is Covered - Prescription Drug Benefits

Express Scripts will provide Pharmacy Benefits under the plan for outpatient Prescription Drug Products:

- Designated as covered at the time the prescription is dispensed when obtained from a Network Pharmacy (Retail, Home Delivery or Specialty Designated Pharmacy), or when a paper claim is filed and the prescription was designated as covered at the time it was dispensed.
- Refer to exclusions in this Section "What' is Not Covered: Prescription Drug Exclusions".

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service.

Benefits for outpatient Prescription Drug Products are available through three types of Network pharmacies: Retail Network Pharmacies; the Express Scripts PharmacySM Home Delivery Service; and Accredo, an Express Scripts Specialty Pharmacy.

You can obtain information about participating Retail Network Pharmacies by calling the toll-free number on the back of your Member ID card, or on the web at Express-Scripts.com/GeorgiaSHBP.

Note: Covered Members that enroll in Disease Management for Diabetes, Coronary Artery Disease (CAD) and Asthma may qualify for the Disease Management (DM) Pharmacy Copay Waiver Program, which allows you to get select medications for these disease states at zero Copayment. If you have Diabetes, Asthma and/or CAD and are interested in participating in the Personal Health Coach Program and learning more about how to qualify for the Copayment waiver incentive, please call UnitedHealthcare at (888) 364-6352.

When a Brand-name Drug Becomes Available as a Generic

When a Brand-name drug becomes available as a Generic Prescription Drug Product, the cost of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the applicable Copayment for the Prescription Drug Product. If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Generic Prescription Drug Product (Generic equivalent), you will pay the applicable Generic Copayment amount as well as the difference in cost between the Brand and Generic Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. You may determine if a Prescription drug has been assigned a supply limit for dispensing call the Express Scripts member services number on the back of your Member ID card or on the web at Express-Scripts.com/GeorgiaSHBP.

Note: Some products are subject to additional supply limits based on criteria that Express Scripts has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

Network Pharmacy Notification (Prior Authorization) or Coverage Review Requirements

When Prescription Drug Products are dispensed at a Network Pharmacy and require notification (also known as Prior Authorization), the prescribing Provider, the Pharmacist or you are responsible for notifying Express Scripts for approval. If Express Scripts is not notified for approval before the Prescription Drug Product is dispensed at a participating Network Pharmacy then the prescription is not eligible for coverage and you will be

required to pay the Full Retail Cost (Usual and Customary Charge) for that prescription at the pharmacy. If Express Scripts is notified within twelve (12) months after the date the prescription was filled and the Notification is retroactively approved then you may request reimbursement from Express Scripts. The Prescription Drug Products requiring Notification are subject to periodic review and modification. You may find out whether a particular Prescription Drug Product requires Notification by consulting your Prescription Drug List through Express-Scripts.com/GeorgiaSHBP or by calling Express Scripts Member Services at the number on your Member ID card.

Note: Notification approval will be required before the claim will be considered for reimbursement. If Express Scripts is notified within 12 months after you pay the Full Retail Cost and the Notification is denied, you will not be reimbursed.

Out-of-Network Pharmacy Notification or If You Do Not Present Your Member ID card

If a prescription is filled by an out-of-network pharmacy or without use of your Member ID card you can submit that claim for reimbursement up to twelve (12) months after the date the prescription was filled. If the drug required notification approval and that was not obtained prior to filling the prescription then it can be requested at the time the claim is submitted. If the notification is not approved, then you will not be able to be reimbursed for your claim.

When you submit a claim on this basis, you may pay more because you did not notify Express Scripts before the Prescription Drug Product was dispensed and because the out-of-network pharmacy you used is not bound by the network pricing under our plan. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and Ancillary Charge, if applicable.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from Express Scripts by calling the Express Scripts Member Services number on your Member ID card, or log into Express-Scripts.com/GeorgiaSHBP. Along with the prescription drug claim form, you will need a pharmacy receipt for your prescription and if applicable- an explanation of benefits (EOB) from your primary carrier.

Requesting Reimbursement for a claim you paid Full Retail Cost

When you use an Out-of-Network Pharmacy, or if you do not show your Member ID card or provide verifiable information at a Network Pharmacy, you must pay the Full Retail Cost (Usual and Customary Charge) for your prescription and then submit a prescription drug claim form to Express Scripts for reimbursement of covered drug costs as has been described above. Assignment of Benefits (AOB) is not available.

The prescription drug claim form must be filled out in its entirety and mailed to the address on this form. Any missing information may cause a delay in processing your reimbursement. Required information includes the pharmacy seven-digit NCPDP number (this number should be identified on your pharmacy receipt), the National Drug Code (NDC) number for your prescription (this can be obtained from your pharmacy), the prescription number, the name of the pharmacy, the physician's name, the member ID number, and the patient's name and date of birth. A pharmacy receipt and an EOB from your primary carrier (if applicable) will also be required along with the claim form.

You will be reimbursed the approved Prescription Drug Cost less the applicable Copayment. Also, you are subject to Benefit plan rules (including but not limited to notification and step therapy) as well as balance billing if the charged amount exceeds the network cost of your prescription(s).

Step Therapy Program Requirements

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products, for which Benefits are described in your Summary Plan Description (SPD), are subject

to Step Therapy Program requirements (also known as Step Therapy). This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products, you are required to use (a) different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to Step Therapy requirements through Express-Scripts.com/GeorgiaSHBP or by calling the Express Scripts Member Services number on your Member ID card.

Clinical Appeal Process

If a notification or quantity limitation request is denied by Express Scripts, you or your physician may initiate the clinical appeals process. Express Scripts recommends that a physician initiate an appeal for a denied notification decision by Express Scripts so that all necessary clinical information can be obtained.

The request/appeal must be submitted in writing (via letter) to Express Scripts for consideration. The appeal must be submitted within 180 calendar days of the date of the denial letter. This is known as the first-level appeal. The written inquiry should be directed to:

Express Scripts Appeals Department
State of Georgia Health Benefit Plan Members
P.O. Box 66588
St. Louis, MO 63166-6588

Express Scripts will advise you in writing of its decision. If Express Scripts upholds the denial, information regarding the second-level appeal process will be provided to you.

Second-level appeals (an appeal to the first-level appeal decision described above) must be initiated by you or your authorized representative and must be received in writing (via letter). Express Scripts recommends that a Physician initiate an appeal for a denied first- level appeal decision by Express Scripts so that all necessary clinical information can be obtained. The second-level appeal must be submitted within 60 calendar days of the date of the first-level appeal denial letter.

The second-level appeal request, along with any new and/or additional supporting documentation, shall be forwarded to Express Scripts to the address above. The second-level appeal decision is the final decision under the plan.

If, after exhausting the two levels of appeal available to you under your plan, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for experimental, investigational or unproven services.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact Express Scripts at the toll-free number on your Member ID card for more information.

Preventive Care Medications

Preventive Care Medications and over-the-counter (OTC) medications are covered as described in the "Prescription Drug Glossary and Definition" in this Section of the SPD. For these Preventive Care Medications to be covered, you must obtain a prescription from your Doctor and meet the age/gender or other requirements. As part of the Patient Protection and Affordable Care Act, certain contraceptive Prescription Drug Products are covered as Preventive Care Medications at no cost to the Member.

You may determine whether a drug is a Preventive Care Medication through Express-Scripts.com/GeorgiaSHBP or by calling the Express Scripts Member Services on your Member ID card. You may not be responsible for paying Copayment for these Preventive Care Medications.

Tobacco Cessation Medications

A 90-day treatment cycle of OTC or prescription tobacco cessation medications is available through a Retail Network Pharmacy at no cost to the member. The 90-day treatment cycle will be dispensed as a 31-day supply with 2 refills allowed. A prescription is required for coverage.

A total of two (2) 90-day treatment cycles are allowed per year at no cost to the member.

The Tobacco Cessation Telephonic Coaching program is available to Covered Members age 18 and older to assist them to become tobacco-free. Please see the Tobacco Cessation Incentive Program in the Wellness Administrator section of this SPD. To enroll in the Tobacco Cessation Incentive Program, please call Healthways at (888) 616-6411.

Patient Safety

Express Scripts monitors for potential safety issues with drug therapy and will communicate alerts to pharmacist at the point-of-sale and directly to the prescribing physicians when appropriate.

Coordination of Benefits (COB)

If your spouse or a dependent has primary coverage from another health plan, or if you or your spouse as a retiree have a Medicare Part D plan, prescription drug benefits provided by the SHBP will be coordinated with the other insurance carrier(s). This means you must first use your primary insurance plan when you pay for your prescription(s).

To request a secondary payment from Express Scripts at the time of purchase, you can request the pharmacist to electronically file SHBP secondary (see below).

Coordination of Pharmacy Benefits between your Medicare Part D plan and SHBP

- If you have a Medicare Part D plan as primary, each time you go to the pharmacy, present both your Medicare Part D and SHBP identification cards.
- When you reach the Medicare Part D coverage gap, you should still present both identification cards and you will pay your SHBP Copayment.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as notification and step therapy, receive approval before your claims may be considered for reimbursement.

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan (PDP) and SHBP

If you have another health plan as primary, each time you go to the pharmacy, present both your primary insurance carrier and SHBP Member ID cards.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Notification and Step Therapy, receive approval before your claims may be considered for reimbursement.

To request a secondary payment from Express Scripts after the time of purchase, you can send a prescription drug claim form and attach a copy of the EOB from the primary plan and the pharmacy receipt. You can obtain a copy of the prescription drug claim form by calling the Express Scripts member services number on your Member ID card, or through Express-Scripts.com/GeorgiaSHBP.

When the SHBP is the secondary plan, benefits are coordinated to pay only the difference between the amount

paid by the primary plan and the allowable amount payable by the SHBP.

Note: The amount paid as secondary payor will not exceed the allowable amount payable by the SHBP. Please call the Express Scripts member services number on your SHBP Member ID card for more details. If you have coverage under two SHBP contracts (cross-coverage or dual coverage), Prescription Drug Benefits provided by the SHBP will not be coordinated. Copayments will be required for each filled prescription. If you have coverage under a Medicare Advantage plan, benefits provided by the SHBP pharmacy benefits will not be coordinated.

Pharmacy Type and Supply Limits

Prescription Drugs from a Participating Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a participating Retail Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one month supply of a cholesterol medication, as an example. You may obtain a three month supply at one time if you pay the applicable Copayment for each month supplied based on the type of pharmacy used (standard retail pharmacy or 90-day network pharmacy).

Note: For covered Prescription Drug Products dispensed from an Out-of-Network Pharmacy, the same rules apply for reimbursement.

If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Generic Copayment in addition to the difference between the Brand and Generic Drug costs.

Note: Pharmacy benefits apply only if your prescription is for a Covered Health Service, and not for experimental, investigational or unproven services. Otherwise, you are responsible for paying 100% of the cost.

Your Copayment is determined by the tier to which the Express Scripts Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the PDL are assigned to Tier 1, Tier 2 or Tier 3. Please consult your PDL at Express-Scripts.com/GeorgiaSHBP, or call the Express Scripts Member Services number on your Member ID card to determine tier status.

Note: Copayment payments will not be overridden or changed on an individual basis.

Coverage for up to a 31-day supply for a participating Retail Network Pharmacy:

Tier 1: $20 Copayment
Tier 2: $50 Copayment
Tier 3: $90 Copayment

Coverage for up to 31-day supply from a Retail Non-Network Pharmacy

In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy. If the out of network pharmacy you use bills more than the plan would reimburse for that same drug to a network pharmacy under their contracted rates then you must pay the difference in cost plus your Copayment as outlined below.

The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one month supply of a cholesterol medication, as an example. You may obtain up to a three month supply at one time if you pay a Copayment for each month supplied.

Coverage for up to a 31-day supply for a non-participating Retail Pharmacy:

Tier 1: $20 Copayment
Tier 2: $50 Copayment
Tier 3: $90 Copayment

Specialty Prescription Drug Products from Accredo, an Express Scripts Specialty Pharmacy

For Benefits provided for outpatient Specialty Prescription Drug Products dispensed by Accredo, an Express Scripts Specialty Pharmacy, the following apply:

- As written by a Physician up to a 31-day supply; or

- Up to a 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a 31-day supply, the Copayment that applies will reflect the number of days dispensed.

You must use Accredo to receive coverage for Specialty Prescription Drug Products. In some cases, you may be allowed to obtain one fill of your Specialty Prescription Drug Product from a participating Retail Network Pharmacy. Thereafter, you will be required to use Accredo to continue coverage for your Specialty Prescription Drug Product. If you do not use Accredo, the Specialty Prescription Drug Product is not eligible for coverage and you will be required to pay the Full Retail Cost for that prescription at the retail pharmacy. To determine whether your specialty drug is allowed any initial retail fills, contact Express Scripts at the number on your card.

Specialty Coverage for up to a 31-day supply from Accredo:

Tier 1: $20 Copayment
Tier 2: $50 Copayment
Tier 3: $90 Copayment

Prescription Drug Products from Express Scripts Home Delivery

The following supply limits apply for Benefits for outpatient Prescription Drug Products dispensed by the Express Scripts Pharmacy Home Delivery Service:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- Your doctor must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills).

Note: You will be charged a 90-day Home Delivery Service Copayment regardless of the days' supply actually dispensed.

To fill the prescription, you may:

- Mail your prescription(s) along with the required form in the envelope provided with your Welcome Package.
- Ask your Doctor to call (888) 327-9791 for instructions on how to fax the prescription. Your Doctor must include your Member ID number.
- Order online after registering at Express-Scripts.com/GeorgiaSHBP.

Note: If you submit a prescription for a 1-month supply to the Express Scripts Pharmacy Home Delivery service, it will be filled but you will be charged the 90-day Copayment amount, so make sure you submit only maintenance prescriptions that you take on a regular basis for a full 90-day supply from Home Delivery.

Coverage up to a consecutive 90-day supply through Home Delivery:

Tier 1: 2 ½ x the monthly Copayment for up to a 90-day supply $50
Tier 2: 2 ½ x the monthly Copayment for up to a 90-day supply $125
Tier 3: 2 ½ x the monthly Copayment for up to a 90-day supply $225

Express Scripts offers two ways to obtain up to a 90-day supply of maintenance drugs.

- Some participating retail pharmacies in our Network allow you to get up to a 90-day supply of maintenance drugs at the home delivery Copayment rates. These are called 90- day retail network pharmacies. To determine which participating retail pharmacies pass through the discounted Copayment rates for a 90-day supply, visit Express-Scripts.com/GeorgiaSHBP and click "Locate a pharmacy." Any participating 90-day retail pharmacy will have the following statement after the address: "Dispenses a maintenance supply: YES". You can also locate participating retail pharmacies on theExpress Scripts mobile app or call Express Scripts at the number on the back of your Member ID Card.
- You can use the Express Scripts Pharmacy Home Delivery Service.

What Is Not Covered – Prescription Drug Exclusions

Exclusions from coverage listed in the SPD apply also to this Rider. In addition, the following prescription drug exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.
2. Drugs that are prescribed dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.
3. Experimental, Investigational or Unproven Services and medications; medications and/or indications not approved by the Food and Drug Administration (FDA) used for experimental indications and/or dosage regimens determined by Express Scripts to be experimental, investigational or unproven.
4. Prescription Drug Products furnished by the local, state or Federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or Federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
5. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
6. Any product dispensed for the purpose of appetite suppression and other weight loss products.
7. An injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by Express Scripts, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to flu, Gardasil, Ceravix and Zostavax vaccines self-administered injectable medications and Specialty medications covered through your Pharmacy Benefit plan.
8. The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
13. Prescription Drug Products when prescribed to treat infertility.
14. Compound drugs which contain any non-covered ingredients and compounds which do not contain at least one ingredient that requires a prescription. Other coverage rules may apply.
15. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, folic acid and Iron – that require a prescription for coverage.
16. Yohimbine.
17. Mifeprex.
18. Blood or blood plasma products except for hemophilia factors.
19. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.
20. Specialty Prescription Drugs purchased at a pharmacy that is not a Specialty Designated Pharmacy (except for the first prescription fill or in some limited cases two prescription fills of the Specialty Prescription Drug, which may be purchased from a Retail Pharmacy).

21. Nutritional supplements, except for those specifically identified as included under the plan. Contact Express Scripts Member Services for a list of covered supplements.
22. Any Prescription Drug Product that is therapeutically equivalent to an OTC drug. Prescription Drug Products that compromise components that are available in OTC form or an equivalent.

Frequently Asked Questions- Prescription Drug

This section will help you understand your medication choices and make informed decisions, plus it will help you understand which questions to ask your Doctor or Pharmacist.

What is a Prescription Drug List (PDL)?

A PDL is a list of FDA-approved Brand-name and Generic medications. The PDL is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

The PDL offers a wide choice of Brand-name and Generic medications that are reviewed by Doctors and Pharmacists on the Express Scripts National Pharmacy and Therapeutics Committee. The list is updated to reflect decisions based on new medical evidence and information. Additionally, the FDA approves all medications, including Generics, which means you can be confident that whatever medication you choose, it meets the strict guidelines set by the FDA.

Your Express Scripts Pharmacy Benefit provides coverage for a comprehensive selection of prescription medications. You can check which medications are on which tiers at Express-Scripts.com/GeorgiaSHBP.. You and your physician can refer to this list to consider prescription medication choices and select the appropriate medication to meet your needs.

Understanding Tiers

Prescription medications are categorized within three tiers which are determined by the Pharmacy Administrator. Each tier is assigned a Copayment, the amount you pay when you fill a prescription, which is determined by the Plan. Consult your Benefit plan documents to find out the specific Copayments that are part of your plan. You and your Doctor decide which medication is appropriate for you.

Tier 1: Your Lowest-Cost Option

- Tier 1 medications are your lowest Copayment option. For the lowest out-of-pocket expense, always consider Tier 1 medications if you and your doctor decide they are right for your treatment.

Tier 2: Your Midrange-Cost Option

- Tier 2 medications are your middle Copayment option.

Tier 3: Your Highest-Cost Option

- Tier 3 medications are your highest Copayment option. If you are currently taking a medication in Tier 3, ask your Doctor whether there are lower-cost Tier 1 or Tier 2 medications that may be right for your treatment.

Note: Compounded medications are medications with two or more ingredients that are prepared "on-site" by a Pharmacist. These are classified at the Tier 3 level.

What factors are looked at when making tier placement decisions, and who decides which medications get placed in which tier?

Several factors are considered when deciding the placement of a medication on the Prescription Drug List, including the medication's classification. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals, including Pharmacists and Physicians with a broad range of specialties.

The two main committees are:

- The Express Scripts National Pharmacy and Therapeutics (P&T) Committee, which evaluates clinical evidence

in order to determine a medication's role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficacy of the medication.

- Express Scripts, which evaluates the clinical recommendations of the P&T Committee as well as pharmacoeconomic and economic information. Once a medication's clinical, pharmacoeconomic and economic value is established, Express Scripts' Value Assessment Committee makes a tier placement decision based on the overall value of the medication. The Value Assessment Committee helps to ensure access to a wide range of affordable medications for you.

How often will Prescription medications change tiers?

Most tier changes will occur on January 1 and July 1. Medications may move to a lower or higher tier. Additionally, when a Brand-name medication becomes available as a Generic, the tier status of the Brand-name medication and its corresponding Generic will be evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Express Scripts will notify members 60 days in advance for formulary changes that result in a drug moving to a higher cost tier. For the most current information on your pharmacy coverage, please call Express Scripts Member Services on your Member ID card or log on to Express-Scripts.com/GeorgiaSHBP.

What is the difference between Brand-name and Generic medications?

Generic medications contain the same active ingredients as Brand-name medications, but they often cost less. Generic medications become available after the patent on the Brand- name medication expires. At that time, other companies are permitted to manufacture an FDA-approved, chemically equivalent medication. Many companies that make Brand-name medications also produce and market Generic medications.

The next time your Doctor gives you a prescription for a Brand-name medication, ask if a Generic equivalent is available and if it might be appropriate for you. While there are exceptions, Generic medications are usually your lowest in cost. Go to Express-Scripts.com/GeorgiaSHBP to determine if an equivalent Generic medication is available.

Why is the medication that I am currently taking no longer covered?

Medications may be excluded from coverage under your Pharmacy Benefit. For example, a Prescription medication may be excluded from coverage when it is therapeutically equivalent to an over-the-counter (OTC) medication. For possible coverage alternatives, please call the Member Service number on your Member ID card.

When should I consider discussing Over-the-Counter or Non-Prescription medications with my doctor?

An OTC medication can be an appropriate treatment for many conditions. Consult your doctor about OTC alternatives to treat your condition. These medications are not covered under your Pharmacy Benefit (except certain Preventive Care medications), but they may cost less than your out-of-pocket expense for Prescription medications.

What is a maintenance medication program?

Maintenance Prescription Drug Products are long-term medications taken to treat an ongoing condition, such as high blood pressure, high cholesterol or diabetes. Maintenance medications are those prescribed medications that a member may obtain for a period of up to 90 days per fill.

You may obtain up to a 90-day supply if your Physician writes a prescription for a 90-day supply. For example, if you take two tablets a day, your Physician must write a prescription for a quantity of 180 tablets to be dispensed.

Please log into Express-Scripts.com/GeorgiaSHBP or call the Express Scripts Member Services number if you have specific questions regarding whether a medication is covered as a maintenance medication. Certain medications have been categorized as maintenance medications.

Which maintenance medications are included in the maintenance medication program?

Maintenance medications include but are not limited to:

- Anti-Parkinson medications.
- Asthma medications that are taken orally, excluding inhalers.
- Cardiovascular medications for hypertension and heart disease.
- Diabetic medications.
- Estrogen and progestin medication.
- Medications for the treatment of epilepsy.
- Oral contraceptives.
- Thyroid medications.

Please call the Express Scripts Member Services number on the back of your Member ID card if you have specific questions regarding whether a medication is covered as a maintenance medication.

What are the supply limits (SL) programs?

The SL program defines the maximum quantity that can be dispensed per Copayment (Quantity Level Limit, or QLL) or specified time frame (Quantity Duration, or QD). Supply limits are based upon the manufacturer's package size, dosing recommendations or guidelines that are included in the FDA labeling, and medical literature and guidelines.

How do the SL programs work?

If your prescription exceeds the supply limit, your pharmacist will be notified of the quantity covered for your Copayment.

You will have the following options:

- Accept the established quantity limit.
- Pay additional out-of-pocket costs that exceed the quantity limits (as appropriate).
- Discuss alternatives with your Doctor before deciding whether to fill the prescription.
- Request Coverage Authorization Review for the additional amounts through the Coverage Review process (when available).

What is a Coverage Review, Notification, or Prior Authorization?

A Coverage Review, Notification, or Prior Authorization (PA) is a set of clinical rules designed to support the Pharmacy Benefit at the time the prescription is dispensed. Applied to a limited number of medications, Notification requires your Doctor to provide additional information to determine whether the use of the medication is covered by your Pharmacy Benefit and to ensure appropriate use.

How does the program work?

If your medication is included in a Notification program, your pharmacy is sent a message on the computer system with instructions to have your Doctor call a toll-free number to get approval for the prescription. Some Pharmacists will contact your doctor while others may request you do so. Your Doctor will provide Express Scripts with information to determine if the prescription meets the coverage conditions of your Pharmacy Benefit. Express Scripts will review the information and approve or deny coverage. Express Scripts will send letters to you and your Doctor explaining the decision and providing instructions on how to appeal if you so desire.

What should I do if I use a self-administered injectable medication?

You may have coverage for self-administered injectable medications through your Pharmacy Benefit plan or

under your Medical Benefits.

Please call Express Scripts Member Services number on your Member ID card to determine whether a medication is covered as a self-administered injectable under your Pharmacy or Medical Benefits.

How do I obtain a supply of my medications before I go on vacation?

You may receive up to a 3 month supply of medication from the Express Scripts Home Delivery Service as long as it is indicated on your prescription. If you are going to run out of medication while you are on vacation, you may receive an early 3-month supply up to two times per year. You will be responsible for the Copayment associated with that supply. There are some limitations with controlled or temperature sensitive medications. For more information, call the Express Scripts Member Services number on your Member ID card.

If you would like to obtain a supply of medication prior to leaving for your vacation, you will need to inform your local Network Pharmacist. Your Pharmacist should know how to process your vacation request, however if not please have your Pharmacist contact the Express Scripts Pharmacy help desk at (800) 922-1557.

You may also locate a Network Pharmacy at your vacation destination by calling the Member Service number on your Member ID card, or log into Express-Scripts.com/GeorgiaSHBP.

How do I access updated information about my Pharmacy Benefit?

Call the Express Scripts Member Services number on your Member ID card for more current information. Or log into Express-Scripts.com/GeorgiaSHBP for the following pharmacy resources and tools:

- Pharmacy Benefit and coverage information.
- Specific Copayment amounts for Prescription medications.
- Possible lower-cost medication alternatives.
- A list of medications based on a specific medical condition.
- Medication interactions and side effects, etc.
- Locate a participating Retail Pharmacy by ZIP code.
- Review your prescription history.

What if I still have questions?

Please call the Express Scripts Member Services number on your Member ID card. Representatives are available to assist you 24 hours a day.

Prescription Drug Glossary And Definitions

This section defines the terms used throughout this Outpatient Prescription Drug Rider.

Ancillary Charge: A charge that, in addition to the Copayment, you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent generic Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the approved Prescription Drug Cost for Network Pharmacies for the Brand-name Prescription Drug Product, and the approved Prescription Drug Cost of the chemically equivalent Prescription Drug Product available.

Brand-name: A Prescription Drug Product that: (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) Express Scripts identifies as a Brand-name product based on available data resources – including, but not limited to, First DataBank– that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as "Brand-name" by the manufacturer, Pharmacy or your Physician may not be classified as Brand-name by Express Scripts.

Covered Person: Either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this chapter are references to a Covered Person.

Copayment/Copay: The portion of the total cost of the claim that must be paid by the Member.

Designated Pharmacy: A pharmacy that has entered into an agreement on behalf of the pharmacy with Express Scripts, or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Full Retail Cost: Also known as Usual and Customary Charges. This is the amount that a Pharmacist would charge a cash-paying customer for a prescription.

Generic: A Prescription Drug Product that: (1) is chemically equivalent to a Brand-name drug; or (2) Express Scripts identifies as a Generic product based on available data resources – including, but not limited to, First DataBank – that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as a "Generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by Express Scripts.

Home Delivery Service: Allows members requiring maintenance medications the convenience of having maintenance medications delivered to the home or office by the plan's Home Delivery pharmacy service (a pharmacy whose primary business is to dispense Prescription drugs or devices under Prescription drug orders and to deliver the drugs or devices, usually to patients' homes, by US mail, a common carrier or a delivery service).

Member or Covered Member: People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Network Pharmacy: A pharmacy that has:

- Entered into an agreement with Express Scripts or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by Express Scripts as a Network Pharmacy.

A Network Pharmacy can be a participating Retail, Home Delivery or Specialty Designated Pharmacy.

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Plan's Pharmacy Administrator's Prescription Drug List Management Committee, or
- December 31st of the following plan year.

Prescription Drug Cost: The rate Express Scripts has contracted with the Network Pharmacies on behalf of SHBP, including a dispensing fee and any sales tax, if applicable, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug Product: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver or a skilled caregiver in the case of certain Specialty medications. For the purpose of Benefits under the plan, this definition includes:

- Inhalers (with spacers).
- Insulin.

The following diabetic supplies:

- Insulin syringes with or without needles.
- Urine/Blood Test Strips & Tapes.
- Lancets.
- Blood Glucose Testing monitors.
- Continuous Glucose Monitor/Transmitters/Sensors.

Preventive Care Medications: The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment) as required by applicable law under any of the following:

- with respect to infants, children and adolescents, evidence- informed preventive care provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication by calling Express Scripts at the number on your Member ID card or at Express-Scripts.com/GeorgiaSHBP.

Specialty Designated Pharmacy: A Specialty Pharmacy that has entered into an agreement on behalf of the pharmacy with Express Scripts or with an organization contracting on its behalf, to provide specific Specialty Prescription Drug Products.

Specialty Prescription Drug Product: A Prescription Drug Product that is generally a high-cost, oral or self-injectable biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs at Express-Scripts.com/GeorgiaSHBP or by calling the number on the back of your Member ID card.

Usual and Customary Charge: The amount that a Pharmacist would charge a cash-paying customer for a prescription.

End of Pharmacy Claims Administrator

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician/Provider (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family members. For children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCP's, call the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

HIPAA Special Enrollment Notice

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:

- The Covered Person's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call the SHBP Member Services Center at 1-800-610-1863 or contact your Benefit Coordinator/Payroll Location.

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option. Following cancer

surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification.

For more detailed information on the mastectomy-related benefits available under the Plan, call the telephone number on the back of your Identification Card.

Newborns' and Mothers' Health Protection Act of 1996

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES

Georgia Department of Community Health

State Health Benefit Plan Notice of Information Privacy Practices

Revised August 4, 2015

The purpose of this notice is to describe how medical information about you, which includes your personal information, may be used and disclosed and how you can get access to this information. Please review it carefully.

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy. DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" (PHI), and includes any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. This notice tells how your PHI is used and shared by DCH and Plan Representatives. DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Only Summary Information is Used When Developing and/or Modifying the Plan. The Board of Community Health, which is the governing Board of DCH, the Commissioner of DCH and the Chief of the Plan administer the Plan and make certain decisions about the Plan. During those processes, they

may review certain reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any individual person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DCH may provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information may only be used by your employer to obtain health insurance quotes from other sources and make decisions about whether to continue to offer the Plan. Please note that DCH, Plan Representatives, and your employer are prohibited by law from using any PHI that includes genetic information for underwriting purposes.

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information, "Enrollment Information" and "Claims Information". "Enrollment Information" includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment.

"Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

Your PHI is Protected by HIPAA. Under HIPAA, employees of DCH and employees of outside companies and other vendors hired or contracted either directly or indirectly by DCH to administer the Plan are "Plan Representatives," and therefore must protect your PHI. These Plan Representatives may only use PHI and share it as allowed by HIPAA, and pursuant to their "Business Associate" agreements with DCH to ensure compliance with HIPAA and DCH requirements.

DCH Must Ensure the Plan Complies with HIPAA. DCH must make sure the Plan complies with all applicable laws, including HIPAA. DCH and/or the Plan must provide this notice, follow its terms and update it as needed. Under HIPAA, Plan Representatives may only use and share PHI as allowed by law. If there is a breach of your PHI, DCH must notify you of the breach.

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI.

HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing.

Claims Administrator Companies: Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers.

Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan; and communicate with the Plan Members and/or their health care providers.

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan.

State of Georgia Attorney General's Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan.

Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI.

Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.

Note: Treatment is not provided by the Plan but we may use or disclose PHI in arranging or approving treatment with providers.

Under HIPAA, all employees of DCH must protect PHI and all employees must receive and comply with DCH HIPAA privacy training. Only those DCH employees designated by DCH as Plan Representatives for the SHBP health care component are allowed to use and share your PHI.

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations. HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following:

Compliance with a Law or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law or to prevent a serious threat to health and safety.

Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities.

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies that may provide you benefits (such as state retirement systems) in order to get information about your eligibility for the Plan and to improve administration of the Plan.

Research Purposes: Your PHI may be given to researchers for a research project, when the research has been approved by an institutional review board. The institutional review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you and/or with your legal personal representative. However, the Plan may provide limited information to the employee about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI.
Plan Representatives may not use or share your PHI for any reason that is not described in this notice without a written authorization by you or your legal representative. For example, use of your PHI for marketing purposes or uses or disclosures that would constitute a sale of PHI are illegal without this written authorization. If you give a written authorization, you may revoke it later.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to Inspect and Obtain a Copy of your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or

incomplete, you may contact the Plan to request a correction.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures.

Right to Ask for a Restriction of Uses and Disclosures or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety.

Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Member Services Center at 1-800-610-1863 or you may download a copy at www.dch.georgia.gov/shbp. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Address to File HIPAA Complaints:

Georgia Department of Community Health
SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, GA 30301
1 800 610 1863

U.S. Department of Health & Human Services
Office for Civil Rights
Region IV
Atlanta Federal Center
61 Forsyth Street SW
Suite 3B70
Atlanta, GA 30303-8909
1 877 696 6775

For more information about this Notice, contact:
Georgia Department of Community Health
State Health Benefit Plan
P.O. Box 1990
Atlanta, GA 30301
1 800 610 1863

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OPT-OUT NOTICE

Election to be Exempt from Certain Federal law requirements in title XXVII of the Public Health Service Act

Date: August 4, 2015

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Group health plans sponsored by state and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Your plan option is self-funded because the Department of Community Health (DCH) pays all claims directly instead of buying a health insurance policy.

The Department of Community Health has elected to exempt your State Health Benefit Plan from the Mental Health Parity and Addiction Equity Act, that includes protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2016 and ending December 31, 2016. The election may be renewed for subsequent plan years.

Centers for Medicare & Medicaid Services
Medicare Part D Creditable Coverage Notice

Important Notice from the Department of Community Health about Your 2016 Prescription Drug Coverage under the State Health Benefit Plan and Medicare for Plan Year:
January 1 – December 31, 2016

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's Prescription Drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable Prescription Drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Part D Drug Plan?

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. If you join a

Medicare drug plan and do not terminate your SHBP coverage, SHBP will coordinate Benefits with the Medicare drug plan coverage the month following receipt of the notice. You should send a copy of your notice to SHBP at: P.O. Box 1990, Atlanta, GA 30301-1990.

IMPORTANT: If you are a retiree and terminate your SHBP coverage, you will not be able to be able to get this SHBP coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, if you don't join within 63 continuous days after your current coverage ends, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the SHBP Member Services Center at: 1-800-610-1863.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare Prescription Drug coverage:

- Visit: www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE at: 1-800-633-4227 (TTY 1-877-486-2048)

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov or call at: 1-800-772-1213 (TTY: 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

From: January 1, 2016 **To:** December 31, 2016
Date: August 4, 2015

Summaries of Benefits and Coverage

Summaries of benefits and coverage describe each Plan option in the standard format required by the Affordable Care Act. These documents are posted here: http://dch.georgia.gov/shbp-plan-documents. To request a paper copy, you may call the SHBP Member Services Center 1-800-610-1863.

Georgia Law Section 33-30-13 Notice:

For 2016, some members will experience premium increases, while some will experience premium decreases depending on their choice of Claims Administrator and plan option. Since some members will experience a premium increase, DCH provides the following notice: "SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is .04% higher than it would be if the Affordable Care Act provisions that take place in 2016 did not apply."

Through effective planning, purchasing and oversight, the Georgia Department of Community Health (DCH) provides access to affordable quality health care to millions of Georgians, including some of the state's underserved and most vulnerable populations. DCH is responsible for Medicaid and PeachCare for Kids®, the State Health Benefit Plan, Healthcare Facility Regulation and Health Information Technology in Georgia. Clyde L. Reese III, Esq., serves as Commissioner for the Georgia Department of Health. To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.