

Summary Plan Description
UnitedHealthcare Choice Plan
for
the State Health Benefit Plan

Group Number: 702030
Effective Date: July 1, 2011

Table of Contents

Introduction..... 1

How to Use this Document.....1

Information about Defined Terms2

Fraud and Abuse.....2

Your Contribution to the Benefit Costs.....2

Customer Service and Claims Submittal2

Section 1: What's Covered--Benefits 4

Accessing Benefits4

Copayment/Coinsurance.....4

Eligible Expenses.....4

Notification Requirements5

Payment Information6

Annual Deductible.....6

Out-of-Pocket Maximum7

Lifetime Maximum*8

Benefit Information.....9

1. Ambulance Services - Emergency only9

2. Dental Services and Oral Care Surgery:9

3. Durable Medical Equipment..... 13

4. Emergency Health Services..... 15

5. Eye Examinations..... 16

6. Home Health Care 17

7. Hospice Care 19

8. Hospital - Inpatient Stay..... 20

9. Infertility Services 21

10. Injections received in a Physician's Office..... 21

11. Maternity 22

12. Mental Health Services 23

13. Nutritional Counseling..... 25

14. Ostomy and Urinary Catheter Supplies..... 26

15. Outpatient Surgery, Diagnostic and Therapeutic Services 27

16. Physician's Office Services 28

17. Professional Fees for Surgical and Medical Services 29

18. Prosthetic Devices 30

19. Reconstructive Procedures..... 33

20. Rehabilitation Services - Outpatient Therapy 35

21. Skilled Nursing Facility 36

22. Spinal Treatment, Chiropractic & Osteopathic Manipulative
Therapy..... 36

23. Substance Use Disorder Services 37

24. Transplantation Services..... 40

25. Urgent Care Center Services 42

26. Wigs 42

Section 2: What's Not Covered--Exclusions ... 43

How We Use Headings in this Section..... 43

We Do Not Pay Benefits for Exclusions 43

A. Alternative Treatments 43

B. Comfort or Convenience 43

C. Dental 44

E. Experimental, Investigational or Unproven Services 45

F. Foot Care.....	45
G. Medical Supplies and Appliances.....	45
H. Mental Health/Substance Use Disorder.....	46
I. Nutrition.....	47
J. Physical Appearance.....	48
K. Providers.....	48
L. Reproduction.....	48
M. Services Provided under Another Plan.....	49
N. Transplants.....	49
O. Travel.....	49
P. Vision and Hearing.....	49
Q. All Other Exclusions.....	50

Section 3: Obtaining Benefits 52

Benefits.....	52
Benefits for Health Services from Non-Network Providers.....	53
Emergency Health Services.....	54

Section 4: When Coverage Begins..... 55

How to Enroll.....	55
If You Are Hospitalized When Your Coverage Begins.....	55
Who is Eligible for Coverage.....	56
Eligible Person.....	56
Dependent.....	57
When to Enroll and When Coverage Begins.....	60
DCH Surcharge Policy.....	61
Enrollment Periods.....	62
Plan Options.....	63

Enrolling A Newly Eligible Dependent.....	64
When Coverage Begins.....	65
Adding Dependents.....	66
Within 31 days of the child becoming disabled.....	67
Qualifying Events that Allow Coverage Changes for Active Members.....	69
How to Request a Change.....	79
General Information about When Coverage Ends.....	79
Events Ending Your Active Coverage.....	80

Section 5: Provisions for Continuing Health Insurance as Eligible Retirees & Considerations for Members Near Retirement and Members with 8 or 10 Years of Service 83

Plan Membership.....	83
Near Retirement.....	83
Eligibility – to continue health insurance and draw an annuity.....	84
Applying for Coverage Continuation.....	86
When Coverage Begins.....	86
When May My Coverage End?.....	87
Continuing Dependent Coverage at Your Death.....	87
Making Changes to Your Retiree Coverage.....	88
Dropping Your Retiree Coverage.....	88
Qualifying Events.....	89
Changes Permitted Without A Qualifying Event.....	93
Retiree Option Change Period.....	93
If You Return to Active Service.....	93

Medicare Coordination of Benefits for Health Reimbursement Account (HRA), High Deductible Health Plan (HDHP) and Health Maintenance Organization (HMO).....	94
Frequently asked Medicare Questions.....	94

Section 6: How to File a Claim..... 96

If You Receive Covered Health Services from a Contracted provider.....	96
Filing a Claim for Benefits.....	96
Urgent Claims that Require Immediate Action.....	98

Section 7: Questions, Complaints and Appeals100

What to Do First.....	100
How to Appeal a Claim Decision.....	100
Appeal Process – How to Appeal an Eligibility Decision.....	101
Appeals Determinations.....	101
Urgent Claim Appeals that Require Immediate Action.....	103
Voluntary External Review Program.....	103

Section 8: Coordination of Benefits.....104

Filing a Claim When Coordination of Benefits (COB) applies.....	104
How COB Works.....	105
How to Tell Which Plan is Primary.....	105
If You Have Dual Plan Coverage.....	106
Other Forms of Duplicated Benefits.....	106

Section 9: Continuation of Coverage under COBRA 107

When Coverage may be Continued.....	107
Unpaid Leaves of Absence.....	107
Continuing Coverage during Approved Disability Leave.....	108
Continuing Coverage under Family and Medical Leave Act (FMLA).....	108
Continuing Coverage during Military Leave.....	109
If You Leave Your Job.....	109
In the Event of an Active Employee’s Death.....	110
Continuation of Coverage.....	110
Continuation Coverage under Federal Law (COBRA).....	111
Qualifying Events for Continuation Coverage under Federal Law (COBRA).....	111
Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA).....	112
Terminating Events for Continuation Coverage under Federal Law (COBRA).....	113

Section 10: General Legal Provisions115

Plan Document.....	115
Relationship with Providers.....	115
Your Relationship with Providers.....	115
Incentives to You.....	116
Interpretation of Benefits.....	116
Administrative Services.....	116
Clerical Error.....	116
Information and Records.....	116

Examination of Covered Persons	117
Workers' Compensation not Affected.....	117
Subrogation and Reimbursement.....	117
Refund of Overpayments.....	118
Limitation of Action.....	118

Section 11: Your Rights and Responsibilities 119

Employee Rights and Responsibilities.....	119
Retiree Rights and Responsibilities	121

Section 12: Department of Community Health Privacy Notice123

Section 13: Glossary of Defined Terms125

Riders, Amendments, Notices135

Outpatient Prescription Drug Rider137

Introduction.....138

Benefits for Outpatient Prescription Drug Products	138
Coverage Policies and Guidelines	138
Identification Card (ID Card) - Network Pharmacy	139
Designated Pharmacies (including Specialty Designated Pharmacy Network)	139
Limitation on Selection of Pharmacies.....	140
Special Programs.....	140

Member Rights and Responsibilities.....	140
UnitedHealthcare Disclaimer	140

Section 1: What's Covered--Prescription Drug Benefits.....141

Benefits for Outpatient Prescription Drug Products	141
When a Brand-name Drug Becomes Available as a Generic	141
Supply Limits	141
Notification (also known as Prior Authorization or Coverage Review) Requirements.....	142
Progression Rx Program Requirements.....	143
Clinical Appeal Process.....	143
How to Fill Your Prescription at a Non-Participating Pharmacy or at a Participating Pharmacy When You Do Not Present Your ID Card.....	144
Coordination of Benefits (COB)	145
What You Must Pay.....	145

Section 2: What's Not Covered--Exclusions . 152

Section 3: Glossary of Defined Terms 154

Section 4: Frequently Asked Questions 156

What is a Prescription Drug List (PDL)?	156
Understanding Tiers	156
What factors are looked at for tier placement decisions and who decides which medications get placed in which tier ?.....	157
How often will prescription medications change tiers?.....	157

What is the difference between brand name and generic medications?	157
Why is a generic drug in Tier 2 or Tier 3?.....	158
Why is the medication that I am currently taking no longer covered?	158
When should I consider discussing over-the-counter or non-prescription medications with my doctor?.....	158
What is a maintenance medication program?.....	158
What maintenance medications are included in the maintenance medication program?.....	158
What are the Supply Limits (SL) programs?.....	159
How do the Supply Limit (SL) programs work?.....	159
What is the Notification program?.....	159
How does the Notification program work?.....	159
What should I do if I use a self-administered injectable medication?.....	159
How do I obtain a supply of my medications before I go on vacation?.....	160
How do I access updated information about my pharmacy benefit?	160
What if I still have questions?.....	160
Attachment I.....	161
Women's Health and Cancer Rights Act of 1998.....	161
Statement of Rights under the Newborns' and Mothers' Health Protection Act.....	161

Introduction

This booklet is your Summary Plan Description (SPD) and describes the provisions of your State Health Benefit Plan (SHBP), which is also referred to in this booklet as the “Plan.” Use this SPD as a reference tool to help you understand the Plan and maximize your coverage.

The SHBP is a self insured Plan, which is governed by the regulations of the Department of Community Health (DCH) Board, Chapter 111-4-1 Health Benefit Plan. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all times.

This booklet is notice to all members of the SHBP’s eligibility requirements and benefits payable for services provided on or after July 1, 2011, unless otherwise noted. Any and all statements to Members or to Providers about eligibility, payment or levels of payment that were made before July 1, 2011 are canceled if they conflict in any way with the provisions described in this booklet.

The SHBP reserves the right to act as sole interpreter of all the terms and conditions of the Plan, including this booklet and the separate medical policy guidelines that serve as supplement to this booklet to more fully define eligible charges.

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

The Summary Plan Description published by UnitedHealthcare for members enrolled in the SHBP does not constitute a contract. The provisions of the program are subject to annual review and modification. Costs may vary each year.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading Section 1: What's Covered--Benefits and Section 2: What's Not Covered--Exclusions. You should also carefully read Section 10: General Legal Provisions to better understand how this SPD and your Benefits work. You should call UnitedHealthcare if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of 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.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

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 13: Glossary of Defined Terms. You can refer to Section 13 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 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 13: Glossary of Defined Terms.

Fraud and Abuse

Please notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-866-242-7727.

Your Contribution to the Benefit Costs

The Plan may require the Member to contribute to the cost of coverage. Contact your benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

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

Customer Service Representative: (i.e. questions regarding Coverage or procedures), 1-877-246-4189, as shown on your ID card.

Prior Notification/Care Coordination: 1-800-955-7976

For detailed explanation on Prior Notification please see page 5.

Mental Health/Substance Use Disorder Services:
1-877-246-4189

Pharmacy Questions: 1-877-246-4189

Plan's Eligibility Unit: 1-404-656-6322, Atlanta

1-800-610-1863, toll-free outside Atlanta

Monday - Friday, 8:30 a.m. to 4:30 p.m.

Membership Correspondence for non-claim/eligibility issues:

State Health Benefit Plan

Membership Correspondence Unit

P.O. Box 1990, Atlanta, GA 30301-1990

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

Claims Submittal Address:

United HealthCare Services, Inc.

Attn: Claims

PO Box 740806

Atlanta, Georgia 30374-0800

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

State of Georgia - State Health Benefit Plan Members

6220 Old Dobbin Lane, FL 2

Columbia, MD 21045

Attn: GDCH-SHBP

Submit requests for Review of Denied Claims/Appeals and Notice of Complaints to:

United HealthCare Services, Inc.

PO Box 30994

Salt Lake City, Utah 84130-0994

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

Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits. Refer to Section 1 “What’s Covered—Benefits and Section 2 “What’s Not Covered--Exclusions
- Copayment/Coinsurance and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in Section 2: What's Not Covered--Exclusions.
- Covered Health Services that require you or your provider to notify Care Coordination before you receive them. In general, Network providers are responsible for notifying Care Coordination before they provide certain health services to you.

Accessing Benefits

You must see a Network Physician to obtain Benefits for covered health services. For details, see Section 3: Obtaining Benefits. You must show your identification (ID) card every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you

are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 9: Continuation of Coverage under COBRA occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment/Coinsurance

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment/Coinsurance, see Section 13: Glossary of Defined Terms. Copayment/Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service.

Note: Copayments are calculated as a set dollar amount. Coinsurance is a percentage based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases, our designee is UnitedHealthcare. For a complete definition of Eligible Expenses that describes how payment is determined, see Section 13: Glossary of Defined Terms.

We have delegated to UnitedHealthcare the discretion and authority to determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills.

Notification Requirements

In general, Network providers are responsible for notifying Care Coordination before they provide services to you. There are some Benefits, however, for which you are responsible for notifying Care Coordination. Please refer to the **Benefit Information** section for additional notification requirements.

Special Note Regarding Medicare

Prior Notification is required for transplant services, Skilled Nursing admissions and home intravenous medication therapy, even if Medicare is primary, and for expenses that Medicare does not cover. You should call Mental Health/Substance Use Disorder Designee whenever you need mental health and substance abuse care, even if you have primary coverage through Medicare or a health plan other than SHBP.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	<p>The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see Section 13: Glossary of Defined Terms. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see Section 13: Glossary of Defined Terms.</p> <p>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.</p>	<p>You Deductible - \$1,000 You + Spouse Deductible - \$1,500 You + Child(ren) Deductible - \$1,500 You + Family Deductible - \$2,000</p> <p>*The deductible amount any one person can satisfy is not be more than the You deductible. Once met, claims are reimbursed according to plan guidelines for that individual.</p>

Payment Term	Description	Amounts
Out-of-Pocket Maximum	<p>The maximum you pay for Covered Health Services in a Plan year for Coinsurance and Annual Deductible. For a complete definition of Out-of-Pocket Maximum, see Section 13: Glossary of Defined Terms.</p> <p>The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p>Copayment amounts are excluded from the Out-of-Pocket Maximum.</p> <p>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.</p>	<p>You Out-of-Pocket - \$3,000 plus Copayments You + Spouse Out-of-Pocket - \$4,500 plus Copayments You + Child(ren) Out-of-Pocket - \$4,500 plus Copayments You + Family Out-of-Pocket - \$6,000 plus Copayments</p>
		<p>*The out-of-pocket amount an individual can meet is not more than the You out-of-pocket amount. Once met, claims are reimbursed at 100% of eligible expenses for that individual. The out-of-pocket can be met cumulatively.</p>

Payment Term	Description	Amounts
<p>Lifetime Maximum* There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan</p>	<p>*Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p>	Unlimited

Benefit Information

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.</p> <p>Non-emergency transportation ground or air transportation of covered member to or from a medical facility, Physician's office, or patient's home is excluded, unless approved by Care Coordination.</p>	<p><i>Ground Transportation:</i> 0%</p> <p><i>Air Transportation:</i> 0%</p>	NA/NA	No

2. Dental Services and Oral Care Surgery:

Notification Required

Please notify UnitedHealthcare by contacting Care Coordination for Dental and Oral Care Services as soon as possible, but at least five business days before follow-up (post Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment).

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>A. Accident only Certain dental services when all of the following are true:</p> <ul style="list-style-type: none"> • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. 	Notify UnitedHealthcare by contacting Care Coordination	Inpatient and Outpatient facility charges 20%	NA/Yes Yes
<p>Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:</p> <ul style="list-style-type: none"> • 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. 	Notify UnitedHealthcare by contacting Care Coordination	Office Visit Copayment \$45	No/NA No
<p>Dental services for final treatment to repair the damage must be both of the following:</p> <ul style="list-style-type: none"> • Started within three months of the accident. • Completed within 36 months of the accident. 			

(Benefit information continued on next page)

Description of Covered Health Service

Your Copayment/Coinsurance Amount
% Coinsurance are based on a percent of Eligible Expenses

Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

Note: Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

B. Oral Care

The Plan will consider coverage only for:

- Reconstructive surgical procedures (including dental implants) for the prompt repair of sound, natural teeth or tissue that were damaged as a result of chemotherapy or radiation treatment and other cancer related treatments with prior approved by Care Coordination,
- 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 Care Coordination policies,

Notify UnitedHealthcare by contacting Care Coordination

Inpatient and Outpatient facility charges 20%

NA/Yes

Yes

Notify UnitedHealthcare by contacting Care Coordination

Oral surgery in an office \$45 Copayment

No/NA

No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Institutional and anesthesia charges associated with a 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. 			
<p>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.</p>			
<p><i>C. Temporomandibular Joint Dysfunction (TMJ)</i> Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Benefits include necessary diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or pathology.</p>	<p>Notify UnitedHealthcare by contacting Care Coordination</p>	<p>Inpatient and Outpatient facility charges 20%</p>	<p>NA/Yes Yes</p>
<p>Benefits are not available for charges or services that are dental in nature, including appliances and orthodontic care.</p>		<p>Office visit Copayment \$45</p>	<p>No/NA No</p>
<p><i>D. Wisdom Teeth (Fully Impacted Only)</i> Fully Impacted wisdom teeth are covered under the medical plan.</p>		<p>\$45 Copayment per visit</p>	<p>No/NA No</p>

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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3. Durable Medical Equipment

Notification Required

Please remember to notify UnitedHealthcare by contacting Care Coordination before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify Care Coordination, no Benefits will be paid. Contact Care Coordination to determine if equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination identifies.

Notify UnitedHealthcare by contacting Care Coordination for items more than \$1,000.

0%

NA/NA

No

Durable Medical Equipment (DME) that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable, except urinary catheters and ostomy supplies.
- Disposable items that are considered an integral part of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Compression stocking (limit two per Plan year).

(Benefit information continued on next page)

**Description of
Covered Health Service**

**Your
Copayment/
Coinsurance
Amount**

% Coinsurance are
based on a percent of
Eligible Expenses

**Does
Copayment/
Coinsurance
Help Meet
Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a wheelchair or scooter.
- A standard Hospital type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, 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. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air conditions, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every Plan year.</p> <p>Care Coordination will determine if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination identifies.</p>			
<p>4. Emergency Health Services</p> <p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. If admitted, refer to the Benefits described under <i>Hospital – Inpatient Stay</i>.</p> <p>You will find more information about Benefits for Emergency Health Services in Section 3: Obtaining Benefits.</p>	\$150 Copayment per visit / 0%	No/NA	No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<h2>5. Eye Examinations</h2>			
<p>A. Medical</p>			
<p>Eye examinations received from a health care provider, for diagnosis and treatment of eye condition.</p>	<p>\$45 Copayment per visit</p>	<p>No/NA</p>	<p>No</p>
<p>Note: We will cover eyeglasses or contact lenses (first pair only) within 12 months of cataract surgery. Refer to <i>Durable Medical Equipment</i> benefits for eye hardware coverage.</p>			
<p>B. Routine</p>			
<p>Network routine eye exam benefits received from a health care provider.</p>	<p>\$45 Copayment per visit</p>	<p>No/NA</p>	<p>No</p>
<p>Network benefits include one routine vision exam, including refraction, to detect vision impairment by a Contracted provider, limited to one every 24 months. Routine eye exams are not subject to the deductible.</p>	<p>A \$200 benefit per Plan year for combination of glasses and/or contacts.</p>		
<p>Vision Discount program available through United Health Wellness 1-800-860-8773.</p>			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?	
<p>6. Home Health Care</p> <p>Notification Required</p> <p>Please remember to notify UnitedHealthcare by contacting Care Coordination for Home Health Care Services. No benefits will be paid if Care Coordination is not notified.</p>	<p>Notify UnitedHealthcare by contacting Care Coordination</p>	<p>0%</p>	<p>NA/NA</p>	<p>No</p>
<p>Services received from a Home Health Agency that are both of the following:</p>				
<ul style="list-style-type: none"> • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. 				
<p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Up to four hours of skilled care services. Benefit limit to 120 visits per Plan year.</p>				
<p>Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p>				
<ul style="list-style-type: none"> • It must be 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. 				
<p>(Benefit information continued on next page)</p>				

**Description of
Covered Health Service**

**Your
Copayment/
Coinsurance
Amount**

% Coinsurance are
based on a percent of
Eligible Expenses

**Does
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Coinsurance
Help Meet
Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

Care Coordination will decide if skilled care is required 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.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?	
<p>7. Hospice Care</p> <p>Notification Required Please notify UnitedHealthcare by contacting Care Coordination for Hospice Care Services.</p>	<p>Notify UnitedHealthcare by contacting Care Coordination</p>	<p>0%</p>	<p>NA/NA</p>	<p>Yes</p>

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact Care Coordination for more information regarding guidelines for hospice care. You can contact Care Coordination at the telephone number on your ID card.

Benefits are limited to 360 days during the entire period of time you are covered under the Plan. Benefits for bereavement are limited to 8 visits per Plan year.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?	
<p>8. Hospital - Inpatient Stay Notification Required</p> <p>Please notify UnitedHealthcare by contacting Care Coordination for Inpatient Hospital Stay.</p> <p>Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). • Acute Inpatient Rehabilitation. <p>Benefits for Physician services are described under <i>Professional Fees for Surgical and Medical Services</i>.</p>	<p>Notify UnitedHealthcare by contacting Care Coordination</p>	<p>20%</p>	<p>NA/Yes</p>	<p>Yes</p>

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>9. Infertility Services</p> <p>Services for the treatment of infertility (for underlying medical condition only) when provided by or under the direction of a Network Physician. We will cover diagnostic testing to rule out a diagnosis, but once diagnosed treatment of infertility services is not covered.</p> <p>Please also refer to Section 2: What's Not Covered -- Exclusions under item L. Reproduction.</p>	20%	NA/Yes	Yes
<p>10. Injections received in a Physician's Office</p> <p>Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.</p>	0% per injection	NA/NA	No
	\$35 PCP/ \$45 Specialist	No/NA	No
	Copayment per visit		

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>11. Maternity</p> <p><i>Physician Services for prenatal, delivery and postpartum</i></p> <p>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.</p>	<p>Notify UnitedHealthcare by contacting Care Coordination</p>	<p>0% after initial \$35 Copayment</p>	<p>No/NA</p>
<p>There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Care Coordination during the first trimester, but no later than one month prior to the anticipated delivery date.</p>	<p><i>Newborn Wellness:</i> 0%</p>	<p>NA/NA</p>	<p>No</p>
<p>We will pay for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • According to Federally Mandated Guidelines we will pay 48 hours for the mother and newborn child following a normal vaginal delivery. • According to Federally Mandated Guidelines we will pay 96 hours for the mother and newborn child following a cesarean delivery. 	<p><i>Hospital Services:</i> Refer to Hospital-Inpatient Stay Section</p>		
<p>(Benefit information continued on next page)</p>			

Description of Covered Health Service

Your Copayment/Coinsurance Amount

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Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Note: The listed Benefits for newborn child apply only if the newborn child is added to the Plan within 90 days of birth and premiums are paid from the month of birth.

12. Mental Health Services

Authorization Required / Notification Required

Please remember that you must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare and get authorization to receive these Benefits in advance of any treatment. The Mental Health/Substance Use Disorder Designee phone number that appears on your ID card is 1-877-702-6342. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.

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

You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare to receive the Benefits.

Hospital-Inpatient Stay

20% per Inpatient Stay

NA/Yes

Yes

Physician's Office Services

\$35/\$45 Copayment per visit

No/NA

No

\$10 Copayment per group visit

No/NA

No

(Benefit information continued on next page)

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Help Meet
Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient services.
- Partial hospitalization/day treatment.
- Intensive outpatient treatment.
- Individual, family and group therapeutic services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care. Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Mental Health Services.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>13. Nutritional Counseling</p> <p>Covered Health Services provided by an approved provider such as a registered or licensed dietician/ nutritionist in an individual or group session for Covered Persons with medical conditions that require a special diet. Examples of such medical conditions include, but are not limited to:</p> <ul style="list-style-type: none"> • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. • Eating Disorders. <p>Benefits are limited to three individual or group sessions during a Covered Person's lifetime for each medical condition.</p>	0%	NA/NA	No

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Maximum?**

**Do You Need
to Meet Annual
Deductible?**

14. Ostomy and Urinary Catheter Supplies

Benefits for ostomy supplies include only the following:

0%

NA/NA

No

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.
- Urinary Catheters.

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

Description of Covered Health Service	Your Copayment/ Coinsurance Amount	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Outpatient Surgery, Diagnostic and Therapeutic Services	<small>% Coinsurance are based on a percent of Eligible Expenses</small>		
Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:	Notify UnitedHealthcare by contacting Care Coordination	NA/Yes	Yes
<ul style="list-style-type: none"> • Surgery and related services. • CT scans • PET scans • MRI • Nuclear Medicine • Other diagnostic tests and therapeutic treatments (including cancer) chemotherapy or intravenous infusion therapy. 	<i>For mammography testing:</i> Non-routine: 20%	NA/Yes	Yes
Benefits under this section include only the facility charge, the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under Professional Fees for Surgical and Medical Services.			

Description of
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16. Physician's Office Services

A. Wellness Care/Preventive Healthcare and Annual Gynecological Exams

Covered Health Services for preventive wellness care includes:

- Well-baby and well-child care.
- Routine physical examinations.
- Vision and hearing screenings.
- Immunizations.
- Routine Mammograms.
- Routine lab/X-ray.
- Routine colonoscopy screenings for colorectal cancer for persons 50 or older.

Preventive services must be billed with appropriate preventive service codes.

Note: Refer to Glossary of defined terms under Preventive/Routine Care definition for a detailed listing of covered preventive services.

(Benefit information continued on next page)

Preventive:
0%

NA/NA

No

*Routine
mammograms:*
0%, regardless of
place of service

NA/NA

No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<i>B. Physician's Office Services - Medical</i> Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	\$35 Copayment per PCP visit	No/NA	No
	\$45 Copayment per Specialist visit	No/NA	No
	No Copayment applies when no Physician charge is assessed.		

17. Professional Fees for Surgical and Medical Services

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

20%	NA/Yes	Yes
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Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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18. Prosthetic Devices

Notification Required

Please remember to Notify UnitedHealthcare by contacting Care Coordination for Prosthetic Devices. If Care Coordination is not notified, no Benefits will be paid.

Notify UnitedHealthcare by contacting Care Coordination

0%

NA/NA

No

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Cochlear implants are covered but are subject to Prior Notification.

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.

(Benefit information continued on next page)

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**Do You Need
to Meet Annual
Deductible?**

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, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every Plan year.

Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network Benefits for non-essential prosthetic devices is limited to \$50,000 per Plan year. This limit applies to the total amount that we will pay for prosthetic devices and does not include any Coinsurance or Annual Deductible responsibility you may have. **Note:** 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.

Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.

(Benefit information continued on next page)

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Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

While the plan provides coverage for upper extremity prosthesis, benefits are limited to the most cost-effective device that restores baseline functionality.

Note: This is a Plan benefit interpretation only, based on available clinical information and current Plan language, and is not intended to influence decisions regarding ongoing medical care.

Description of
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Out-of-Pocket
Maximum?

Do You Need
to Meet Annual
Deductible?

19. Reconstructive Procedures

Authorization Required / Notification Required

Please remember to Notify UnitedHealthcare by contacting Care Coordination in advance of any treatment and obtain authorization to receive Benefits for reconstructive procedures.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non affected breast to achieve symmetry. 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.

Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function.

(Benefit information continued on next page)

Notify
UnitedHealthcare
by contacting
Care
Coordination in
advance of any
treatment

Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic, Therapeutic Services and Prosthetic Devices.

**Description of
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Maximum?**

**Do You Need
to Meet Annual
Deductible?**

Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures.

Note: Breast reductions may or may not be considered cosmetic; therefore are subject to prior notification.

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.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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20. Rehabilitation Services - Outpatient Therapy

\$25 Copayment per visit

No/NA

No

Short-term outpatient rehabilitation services for:

- Physical therapy*. (40 visits per Plan year).
- Occupational therapy. (40 visits per Plan year).
- Speech therapy. (40 visits per Plan year).
- Pulmonary rehabilitation therapy. (40 visits per Plan year).
- Cardiac rehabilitation therapy. (40 visits per Plan year).

*Physical Therapy benefits may be extended beyond 40 visits for children up to age 19 with Congenital Anomalies that require surgical correction. The child will also have to be in case management and meet medical necessity criteria.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

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.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>21. Skilled Nursing Facility</p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Benefits are limited to 120 days per Plan year.</p> <p>Note: Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.</p>	20%	NA/Yes	Yes
<p>22. Spinal Treatment, Chiropractic & Osteopathic Manipulative Therapy</p> <p>Benefits for Spinal Treatment when provided by a Network Spinal Treatment provider in the provider's office.</p> <p>Benefits include diagnosis and related services and are limited to one visit and treatment per day.</p> <p>Benefits for Spinal Treatment are limited to 20 visits per Plan year.</p>	\$45 Copayment per visit	No/NA	No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?	
<p>23. Substance Use Disorder Services</p> <p>Authorization Required / Notification Required</p> <p>Referrals to a Substance Use Disorder provider are at the sole discretion of the Mental Health/Substance Use Disorder Designee at UnitedHealthcare, who is responsible for coordinating all of your care. Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Substance Use Disorder Services. The Mental Health/Substance Use Disorder Designee phone number that appears on your ID card is 1-877-702-6342.</p>	<p>You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare to receive the Benefits.</p>	<p><i>Hospital-Inpatient Stay</i></p> <p>20% per Inpatient Stay</p> <p><i>Physician's Office Services</i></p> <p>\$35/\$45 per visit</p> <p>\$10 Copayment per group visit</p>	<p>NA/Yes</p> <p>No/NA</p> <p>No/NA</p>	<p>Yes</p> <p>No</p> <p>No</p>
<p>Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.</p>				
<p>Benefits for Substance Use Disorder Services include:</p> <ul style="list-style-type: none"> • Substance Use Disorder or chemical dependency evaluations and assessment; • Diagnosis; • Treatment planning; 				
<p>(Benefit information continued on next page)</p>				

Description of Covered Health Service

Your Copayment/Coinsurance Amount

% Coinsurance are based on a percent of Eligible Expenses

Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

- Detoxification (sub-acute/non-medical);
- Inpatient services;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- Referral services;
- Medication management;
- Individual, family and group therapeutic services; and
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

(Benefit information continued on next page)

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Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as part of your Substance Use Disorder Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, and Outpatient Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?	
<p>24. Transplantation Services</p> <p>Notification Required</p> <p>Please notify UnitedHealthcare by contacting Care Coordination at 1-800-955-7976, as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).</p>	<p>Notify UnitedHealthcare by contacting Care Coordination in advance of any transplant</p>	<p>20%</p>	<p>NA/Yes</p>	<p>Yes</p>
<p>Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Care Coordination at the telephone number on your ID card for notification and information about these guidelines.</p>				
<p>Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:</p>				
<ul style="list-style-type: none"> • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. • Cornea transplants (You are not required to notify United Resource Networks or Care Coordination of a cornea transplant nor is the cornea transplant required to be performed at a Designated United Resource Networks Facility). 				
<p>(Benefit information continued on next page)</p>				

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Heart transplants, lung transplants or heart/lung transplants. Kidney transplants, pancreas transplants or kidney/pancreas transplants. Liver transplants, small bowel transplants or liver/small bowel transplants. Other transplants deemed appropriate by Care Coordination. 			
<p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.</p>			
<p>Transportation and Lodging</p>			
<p>Care Coordination will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel and lodging for the transplant recipient and a companion are available under this Plan as follows:</p>	20%	NA/Yes	Yes
<ul style="list-style-type: none"> Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up. Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people. 			
<p>(Benefit information continued on next page)</p>			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Coinsurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the \$100 per diem rate. <p>There is a combined overall lifetime maximum Benefit of \$10,000 per Covered Person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.</p>			
<p>25. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under <i>Physician's Office Services</i> earlier in this section.</p>	\$35 Copayment per visit	No/NA	No
<p>26. Wigs Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment.</p> <p>There is a lifetime maximum of \$750 for wigs.</p>	0%	NA/NA	Yes

Section 2: What's Not Covered-- Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions regardless of medical necessity. This section lists some (but not all) of the things the plan does not cover at all, under any circumstances.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: What's Covered--Benefits or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Environmental Medicine services or homeopathic/holistic/alternative medicine services, including visits, diagnostic testing, labs, medication, or procedures.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers.
 - Humidifiers.
6. Devices and computers to assist in communication.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
8. Air cleaners and dust collection device.
9. Vacuum erection devices (VED, erect aid) to stimulate the penis.
10. Duplication, upgrade or replacement of currently function equipment.

C. Dental

1. Dental care except as described in Section 1: What's Covered--Benefits under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, partially impacted wisdom teeth, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
3. Dental implants or associated services such as bone grafts for the placement of dental implants.
4. Dental braces and Orthodontics.

5. 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, except as described in Section 1: What's Covered--Benefits under the heading *Dental Services - Accident Only*.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly, including but not limited to Cleft Palate.
7. Alveoplasty; vestibuloplasty, apicoectomy; excision of mandibular tori or exostosis; occlusal devices or their adjustment; splints for bruxism (clenching or grinding of teeth).
8. Surgery, appliances or prostheses such as crown, 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 or oral service or supply.

D. Drugs ****Please refer to Outpatient Prescription Drug Rider.**

1. Prescription drug products for outpatient use that are filled by a prescription.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.

4. Over-the-counter drugs and treatments except for certain preventive OTC drugs – Aspirin, Fluoride, Folic acid and Iron which require a prescription for coverage.
5. Growth hormone therapy.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses), with the exception of enrollees with diabetes or enrollees who are at risk of neurological or vascular diseases such as diabetes.
2. Nail trimming, cutting, or debriding, with the exception for diabetic foot care.
3. Hygienic and preventive maintenance foot care. Examples include the following:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
4. Treatment of flat feet, fallen arches and chronic foot strain.
5. Treatment of subluxation of the foot.

6. Foot care devices such as arch supports and orthotics (except for the diagnosis of diabetes).
7. Shoes and footwear of any kind (except for therapeutic diabetic shoes) unless permanently attached to a covered brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies (except when considered an integral part of covered Durable Medical Equipment). Examples include:
 - Ace bandages.
 - Gauze, dressings and tape.
 - Lubricants and saline solution.
 - Syringes.
 - Surgical masks and gloves.
 - Batteries and battery chargers.
 - Diabetic supplies, including but not limited to glucose monitors, test strips and lancets. **** Please refer to Outpatient Prescription Drug Rider.**
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1: What's Covered--Benefits.
5. Hot and cold packs.
6. Breast pumps.
7. Blood pressure cuffs (unless related to dialysis).

8. Lift for scooters and wheelchairs, stair glides and elevators, and any other home modifications.
9. Devices and computers to assist in communication.
10. Vacuum erection devices (VED, erect aid) to stimulate the penis.
11. Duplication, upgrade or replacement of currently functioning equipment.
12. Repair or replacement of Durable Medical Equipment due to damages caused by misuse, malicious breakage or gross neglect.
13. Replacement of lost or stolen Durable Medical Equipment.

H. Mental Health/Substance Use Disorder

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. Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
3. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Mental Health/Substance Use Disorder Designee.

5. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Mental Health/Substance Use Disorder Designee.
7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following: (1) not consistent with generally accepted standards of medical practice for the treatment of such conditions; (2) not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; (3) typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; (4) not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time; or (5) not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

8. Recreational, educational or bio-feedback therapy, unless specifically approved by Mental Health/Substance Use Disorder

- Designee, or any form of self-care or self help training or related diagnostic testing.
9. Marriage counseling, unless approved in advance by Mental Health/Substance Use Disorder Designee and conducted by a Mental Health/Substance Use Disorder Designee authorized provider.
 10. Pastoral counseling.
 11. Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Use Disorder (MH/SUD) Administrator.
 12. Substance Use Disorder Services for the treatment of nicotine or caffeine use.
 13. Weight management programs not related to psychiatric condition.
 14. Psychoanalysis, to complete degree or residency requirements.
 15. Vocational or educational training/services and related psychological testing.
 16. Hypnosis.
 17. Routine use of psychological testing without specific authorization.
 18. Experimental treatment performed for research.
 19. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SUD Administrator.
 20. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
 21. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
 22. Learning motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 23. Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 24. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.
 25. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 26. Family therapy when patient is not present.
 27. Residential treatment, Residential treatment facility, sub-Acute care; services of halfway house, supervised group home or boarding school.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups except as specifically described in Section 1: What's Covered--Benefits.
3. Nutritional and electrolyte supplements, including infant formula and donor breast milk. Enteral feedings are not covered except if it is the sole source of nutrition or for inborn errors of metabolism when approved by Care Coordination.
4. Minerals or metabolic deficiency formulas (except when approved by Care Coordination).

J. Physical Appearance

1. Cosmetic Procedures. See the definition in Section 13: Glossary of Defined Terms. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 1: What's Covered--Benefits.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for wigs required as a result of cancer.
6. Hair removal, including electrolysis.
7. Blepharoplasty (upper or lower eyelid), browplasty, brow lift (except when approved by Care Coordination).

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free standing or Hospital based diagnostic facility without an order written by a Physician or other provider. Services that are self directed to a free standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free standing or Hospital based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

L. Reproduction

1. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures and any other reproductive technology.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Infertility monitoring, correction or treatment.
5. Storage of egg, sperm or blood product for future use.
6. Infertility drugs and reproductive medicines.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in Section 1: What's Covered--Benefits.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services and expenses for transplants involving artificial, mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.

6. Any multiple organ transplants not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 1: What's Covered--Benefits.
7. Lodging related to, except as defined in Section 1: What's Covered --Benefits *Transplantation Services* the donation or transplantation of an organ.
8. Transplant therapy used as a palliative procedure. Transplant therapy considered experimental.
9. Some travel expenses related to covered transplantation services may be reimbursed as outlined in the Transplantation Service Section.

O. Travel

1. Travel or transportation expenses, even though prescribed by a Physician.

P. Vision and Hearing

1. Purchase cost of hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy and/or orthoptic training.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery, including LASIK.
5. 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.
6. Tinnitus therapy, including sound generators.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 13: Glossary of Defined Terms.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services 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 the Plan.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature.
8. Medical and surgical treatment of obesity/morbid obesity including, but not limited to, bariatric surgical procedures, gastric restrictive procedures, gastric bypass procedures, weight reduction surgery and revisions. Non-surgical treatment of obesity/morbid obesity, for example Optifast, Weight Watchers, Jenny Craig, etc. Panniculectomy, abdominoplasty, repair of diastasis recti, tummy tuck, excision of excessive skin and/or subcutaneous tissue, and liposuction.
9. Sex transformation operations.
10. Custodial Care.
11. Domiciliary care.
12. Private duty nursing.
13. Respite care.
14. Rest cures.
15. Psychosurgery.
16. Treatment of benign gynecomastia (abnormal breast enlargement in males).
17. Medical and surgical treatment of excessive sweating (hyperhidrosis).
18. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
19. Oral appliances for snoring.
20. 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.
21. 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.

22. 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.
23. Any charges for missed appointments, room or facility, reservations, completion of claim forms or record processing.
24. Any charge for services, supplies or equipment advertised by the provider as free.
25. Any charges prohibited by federal anti-kickback or self-referral statutes.

Section 3: Obtaining Benefits

This section includes information about:

- Obtaining Benefits.
- Provider Network
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Note: Mental Health and Substance Use Disorder Services must be authorized by the Mental Health/Substance Use Disorder Designee. Please see Section 1: What's Covered--Benefits under the heading for *Mental Health and Substance Use Disorder*.

Provider Network

UnitedHealthcare arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of UnitedHealthcare. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Upon request, a Provider directory is available for you. However, before obtaining services you should always verify the Network for status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare or by referring to www.welcometouhc.com/shbp website.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory; contact UnitedHealthcare for assistance or access www.welcometouhc.com/shbp website.

*Care Coordination*SM

Your Network Physician is required to notify Care Coordination regarding certain proposed or scheduled health services. When your Network Physician notifies Care Coordination, they will work together to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify Care Coordination. The Covered Health Services for which notification is required is shown in Section 1: What's Covered--Benefits. When you notify Care Coordination, you will be provided with the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify Care Coordination of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify Care Coordination in advance and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify Care Coordination, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, UnitedHealthcare will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. Non-Emergency use of the Emergency Room is not covered.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, UnitedHealthcare must be notified within one business day or on the same day of admission if reasonably possible. UnitedHealthcare may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date UnitedHealthcare decides a transfer is medically appropriate, Benefits will not be available.

True Emergency Eligible Medical Services rendered outside of United States are covered subject to plan 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 form can be obtained at www.welcometouhc.com/shbp.

Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person should contact his or her Payroll location for instructions on enrolling within 31 days of hire. SHBP will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, SHBP will pay Benefits from the day coverage begins for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify Care Coordination within 48 hours of the day your coverage begins, or as soon as reasonably possible. In-Network Benefits are available only if you receive Covered Health Services from Contracted providers.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	<p>You are eligible to enroll yourself and your eligible dependents for coverage if you are:</p> <ul style="list-style-type: none"> • A Full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP, as long as: <ul style="list-style-type: none"> — You work at least 30 hours a week consistently, and — Your employment is expected to last at least nine months. <p style="margin-left: 40px;">Not Eligible: employees working as an independent contractor or on a temporary, seasonal or intermittent basis.</p> • A certified public school teacher or library employee who works half-time or more, but not less than 17.5 hours a week. <p style="margin-left: 40px;">Not Eligible: Temporary or emergency employees.</p> • A non-certified service employee of a local school system who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week. <p style="margin-left: 40px;">Not Eligible: temporary or emergency employees.</p> • An employee who is eligible to participate in the Public School Employees' Retirement System as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week and not employed on an emergency or temporary basis. 	<p>SHBP determines who is eligible to enroll under the Plan.</p>

(Information continued on next page)

Who	Description	Who Determines Eligibility
Dependent Eligible Dependents are:	<ul style="list-style-type: none"> • A retired employee of one of these listed groups who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state sponsored or state related retirement system. See Provisions for Eligible Retirees for details of retiree medical coverage. • An employee in other groups as defined by law. <hr/> <ul style="list-style-type: none"> • Your legally married spouse; as defined by Georgia law. <ol style="list-style-type: none"> (1) Natural or legally adopted children or Stepchildren, under age 26. Natural Child – child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth. Adopted Child – eligibility begins on the date of legal placement for adoption. Stepchild – eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age 26 or at the end of the month in which he or she loses status as a step child of the enrolled member, whichever date is earlier. (2) Other children under 26. A dependent child for whom the enrolled member is the legal guardian. Eligibility begins on the date legal guardianship is established and ends at the end of the month in which the child reaches age 26 or at the end of the month in which the legal guardianship terminates, whichever is earlier. (3) Your natural children, legally adopted children or stepchildren 26 or older from categories 1 and 2 above who are physically or mentally disabled prior to age 26, lives with the Enrolled member or is institutionalized and depends primarily on the Enrolled member for support and maintenance. 	SHBP determines who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
<p>For a Covered Dependent age 26 & older and disabled before age 26</p>	<p>You must:</p> <ul style="list-style-type: none"> • file a written request for continuation of coverage within 31 days of the 26th birthday. • when requested by the Plan you must re-certify your dependent(s). If you fail to re-certify your dependent within 31 days of the request, your dependent will no longer be eligible to be covered under the Plan until verification is received. If documentation is received after 31 days, the plan will cover the dependent retroactively to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid. 	<p>SHBP determines who qualifies as a Dependent.</p>
<p>To enroll a disabled child as a new dependent (child must be disabled prior to age 26)</p>	<p>You must:</p> <ul style="list-style-type: none"> • make request within 31 days of your hire date or qualifying event date, OR • add during Open Enrollment period, • provide medical documentation that must be approved by the Plan. <p>A general note regarding documentation sent to the Plan: While the Plan requires that coverage requests are made within a specific time period, the documentation required <i>to support your request</i> may be filed later, if necessary within the 31 days following the deadline to file the coverage request.</p>	

Who	Description	Who Determines Eligibility
Qualified Medical Child Support Order (QMCSO)	SHBP will honor a QMCSO for eligible dependents. A QMCSO creates, recognizes, or assigns the right for a dependent to receive benefits under a health plan. See Glossary of Key Terms and Coverage Changes At Qualifying Events for more information.	SHBP determines who qualifies as a Dependent.
Who's Not Eligible For Dependent Coverage	<p>The most common examples of persons not eligible for SHBP dependent coverage include:</p> <ul style="list-style-type: none"> • Your former spouse • Your fiancé • Your parents • Children age 26 or older who do not qualify as disabled dependents • Grandchildren who cannot be considered eligible dependents <p>Anyone living in your home that is not related by marriage or birth, unless otherwise noted.</p>	

When to Enroll and When Coverage Begins

You must enroll to have SHBP coverage

To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option
- Choose a coverage tier
- Provide the name(s) of eligible dependents you want to enroll and cover

Enrollment authorizes periodic payroll deductions for premiums. If you list dependent(s) you must elect a coverage tier that covers the dependent relationship to you. If you cover dependents and do not provide documentation to verify eligibility you will be charged the tier you elected. Once dependents are verified, the coverage will be effective from the date of the qualifying event or the 1st day of the current plan year, whichever is later. Please refer to “Who is eligible for coverage” for more information. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts mid-year changes to coverage in the SHBP.

Special Note: If you terminate employment and are re-hired by any employer eligible for the SHBP during the same Plan year, you must enroll in the same Plan option and tier, provided you are eligible for that option and have not had a qualifying event since coverage ended.

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- Enrolled Member – You, the contract/policy holder
- Dependent(s) – your eligible dependent(s) that you choose to enroll

Where appropriate, this SPD relies on these terms throughout the document:

- Employee, retiree or member to refer to Enrolled Member
- Dependent(s)... to refer to Dependent(s)

DCH Surcharge Policy

Spousal Surcharge:

A spousal surcharge of \$50 will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. The spousal surcharge can be removed in certain circumstances by completing the spousal surcharge affidavit and attaching the required documents. Details can be found on the Department of Community Health website, www.dch.georgia.gov/shbp.

Tobacco Surcharge:

A tobacco surcharge of \$80 will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous twelve months. The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details can be found on the Department of Community Health website, www.dch.georgia.gov/shbp.

Note: Surcharges do not apply to options that include Medicare Advantage (MA) coverage or to retirees who are eligible and did not enroll in a MA option and chose another option where they pay 100 percent of the premiums for their health coverage.

Intentional misrepresentation in response to surcharge questions will have significant consequences. You will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response is discovered.

Enrollment Periods

When to Enroll	Who Can Enroll	Enrollment Information
<p>Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Enrollment must be completed within 31 days of your date of hire.</p>
<p>Open Enrollment Period</p>	<p>Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents.</p> <p>Any dependent(s) removed during the Open Enrollment period are not eligible for COBRA.</p>	<p>The SHBP determines the Open Enrollment Period. Coverage begins on January 1st of the following Plan year</p>
If You Are:	You Can:	Coverage Takes Effect:
<p>A current employee*</p>	<ul style="list-style-type: none"> • Make coverage changes during Open Enrollment • Make coverage changes within 31 days of a qualified event (90 days for newborn) <p>(Refer to the <i>Dependent</i> heading in this Section)</p>	<ul style="list-style-type: none"> • The upcoming January 1 • First of the month following request
<p>A newly hired employee*</p>	<ul style="list-style-type: none"> • Within 31 days of your hire date 	<ul style="list-style-type: none"> • First of the month after a full calendar month of employment

Plan Options

If You Are:	You Can:	Coverage Takes Effect:
<p>An eligible employee terminating employment An eligible employee terminating employment with a participating employer and hired by another participating employer or later rehired by same employer.</p>	<p>If this occurs within the same plan year, you must retain the same option you had under your prior employer, even if there is a gap in coverage.</p> <p>If the termination is in one year and you are hired in the following year, with a gap in coverage, you are restricted to the consumer driven health plan options: the Health Reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP) with the new employer. Once enrolled, you may elect any available health plan option during the following Open Enrollment.</p>	

*If you are enrolling in the health plan for the first time, after a break in coverage or because of a qualifying event, your plan options are restricted to the Health Reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP), which are consumer driven health plan options for the first plan year. Once enrolled, you may elect any available health plan during the following Open Enrollment.

Enrolling A Newly Eligible Dependent

If you have a new dependent due to marriage, birth, adoption, guardianship or a child becoming disabled, you may enroll your dependent(s) if you request coverage within 31 days of the qualifying event (90 days to add newborn). Please contact your personnel/payroll office for instructions.

The SHBP must collect the Social Security Number (SSN) for each dependent age two or older. Do not wait for verification documentation to enroll dependent(s).

The next section describes what you need to do if you wish to add a newly eligible dependent.

	To Enroll A Newly Eligible Dependent And...	You Will Need To:
Newly Eligible Dependent	<ul style="list-style-type: none"> • If your dependent is currently eligible for the tier you are enrolled in • If your current tier does not cover dependents 	<ul style="list-style-type: none"> • You must add within 31 days of the marriage, or adoption (90 days for newborn) • You must change tier within 31 days of qualifying event, pay appropriate premium, and add dependent • You must add within 90 days of the birth regardless if natural, legal or step child
	<ul style="list-style-type: none"> • If you have a court order, requiring you to enroll dependent child(ren) 	<ul style="list-style-type: none"> • Enroll in coverage • Enroll the eligible child(ren); coverage starts on first day of month following the request. • You must change tier and pay appropriate premium if current tier does not include dependent(s)

Identification Cards

After you enroll, you will receive an identification (ID) card for yourself and eligible dependent(s), if applicable. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of new enrollment, or by January 1st from changes made during Open Enrollment or the Retiree Option Change Period, please contact United HealthCare Services, Inc. Customer Service at 877-246-4189 (Active) or 877-246-4190 (Retiree).

When Coverage Begins

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

	If You Enroll:	Your Coverage Begins:
For Transferring Employees	<p>If you are transferring between participating employers:</p> <ul style="list-style-type: none"> • Contact your new employer to coordinate continuous coverage • You must continue the same coverage, unless you had a qualifying event that allows a change in coverage 	<ul style="list-style-type: none"> • There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck.
For You	<ul style="list-style-type: none"> • During an Open Enrollment period • As a new employee • When you are reinstated or return to work from an unpaid leave of absence that occurred during an Open Enrollment period • When you have a qualifying event 	<ul style="list-style-type: none"> • On January 1st of the new Plan year • On the first day of the month following one full calendar month of employment • On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement • On the first day of the month following the request
For Your Dependents	<p>As a new employee, dependent coverage begins when your coverage begins. If you add dependents within 31 days (90 days for newborn) of a qualifying event, coverage takes effect as described in this Section under the heading <i>Adding Dependents</i> and the chart on the next page. The Centers for Medicare & Medicaid Services (CMS) regulations now require the SHBP to collect the Social Security Number (SSN) for each covered dependent. You must submit the following documentation to: SHBP, P. O. Box 1990, Atlanta, Georgia 30301-1990 before claims will be paid. The SHBP will not require the SSN until age two.</p>	
See Chart on next page for required Documentation	<p>Note: Do not hold request waiting for documentation. If documentation is received after 31 days, the plan will cover the dependent retroactively back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as premiums are paid.</p>	

Adding Dependents

When you add a dependent the Plan will request dependent verification documentation. You must submit the documentation requested by the Plan in order to cover the dependent. **CMS regulations now require the SHBP to capture the Social Security Number (SSN) for each covered dependent. If documentation and the SSN is received after 31 days (except for newborn), the plan will cover the dependent retroactively back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid.**

Note: The dependent’s coverage will remain inactive until the appropriate documentation has been received and verified by SHBP.

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
<p>A baby Within 90 days prior to or after the qualifying event</p>	<ul style="list-style-type: none"> • Copy of certified birth certificate or a birth card issued by the hospital listing parents by name <p>Note: A confirmation of birth document that does not include the parents’ names is not acceptable.</p>	<ul style="list-style-type: none"> • On the first day of the month following the request; or • On the day your child was born, if the proper premium is paid for the birth month; forward
<p>An adopted child Within 31 days prior to or after the qualifying event (90 days if adopted child is a newborn)</p>	<ul style="list-style-type: none"> • A certified copy of court documents establishing adoption and stating the date of adoption or if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption 	<p>When you already have coverage that includes children:</p> <ul style="list-style-type: none"> • On the date of legal placement and physical custody <p>When you do not have a tier that covers dependent children</p> <ul style="list-style-type: none"> • On the date of legal placement and physical custody, if the correct tier premium is paid from the time of placement and custody forward

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
<p>Disabled Child</p> <p>Within 31 days of the child becoming disabled</p> <ul style="list-style-type: none"> • Be un-able to be self supporting because of mental or physical disability. • Depend mainly on the Member for support. • Disabled Child does not have to be covered under SHBP prior to age 26, but must have been disabled prior to age 26. • Dependent must meet SHBP disability requirements 	<ul style="list-style-type: none"> • Copy of certified birth certificate or a certification letter of birth • Social Security Number • We will ask you to furnish SHBP with proof of the child's disability and dependency within 31 days of: <ul style="list-style-type: none"> — Enrollment in the plan or — date coverage would otherwise have ended because the child reached age 26 <p>SHBP may continue to ask you for proof that the child continues to meet these conditions of disability and dependency.</p>	<ul style="list-style-type: none"> • On the first of the month following approval of the medical documentation submitted to SHBP • When you have changed tiers to cover the dependent child

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
<p>A new spouse Within 31 days prior to or after the qualifying event</p>	<ul style="list-style-type: none"> • Copy of certified marriage certificate and Social Security Number 	<ul style="list-style-type: none"> • On the first day of the month following the request
<p>Stepchild(ren) Within 31 days prior to or after the qualifying event (90 days if a newborn)</p>	<ul style="list-style-type: none"> • Copy of certified birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out and Social Security Number. <p>Note: A confirmation of birth document that does not include the parent's name is not acceptable.</p>	<ul style="list-style-type: none"> • On the first day of the month following the qualifying event or your change to the appropriate coverage tier
<p>A natural child due to a Qualified Medical Child Support Orders (QMCSO)</p>	<ul style="list-style-type: none"> • Social Security Number • Copy of QMCSO listing children that you must cover 	<ul style="list-style-type: none"> • On the first day of the month following the request

Qualifying Events that Allow Coverage Changes for Active Members

If you are an actively employed Member and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the qualifying event. If you are a retiree, refer to the retiree section for permitted coverage changes. **CMS regulations now require the SHBP to capture the Social Security Number (SSN) for each covered dependent.**

Please contact your personnel/payroll office for instructions. Changes must be reported within 31 days of the event (90 days for newborn) to your personnel/payroll office or to the SHBP by calling 1-800-610-1863.

Note: Loss of all covered dependents may be through divorce, death, an only covered dependent exceeding the maximum age of eligibility, or a Qualified Medical Child Support Order (QMCSO) requiring a former spouse to provide health coverage for all covered natural children. You must notify SHBP within 31 days of qualifying event to change your coverage tier (90 days for newborn). Your next opportunity to change coverage tier would be during the next Open Enrollment.

The following chart shows qualifying events and the corresponding changes that active Members can make:

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 90 Days Of Qualifying Event, You May / Must:
<p>Birth</p> <p>Note: The Social Security Number is not required until age two.</p>	<ul style="list-style-type: none"> • Birth: Copy of certified birth certificate or birth card issued by the hospital listing parents by name. 	<ul style="list-style-type: none"> • Enroll in coverage • Change coverage tier • Enroll eligible dependents • Change to any available option for you + child(ren) or you + family • Enroll eligible dependents

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
Marriage	<ul style="list-style-type: none"> • Certified copy of marriage certificate required • Spouse’s Social Security Number 	<ul style="list-style-type: none"> • Enroll in coverage • Change coverage tier to include spouse • Change coverage option to elect new coverage for you + spouse or you +family • Discontinue coverage; letter from other plan documenting you and your covered dependents are enrolled in spouse’s plan. The letter should include the names of all covered dependents.
<p>Adoption (90 days if adopted child is a newborn), legal guardianship or child becoming disabled</p> <p>Note: The Social Security Number is not required until age two.</p>	<ul style="list-style-type: none"> • Adoption: Adoption certificate or court order placing child in home • Legal guardianship: Certified copy of court documents establishing adoption and stating the date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If certified copy of the birth certificate is not available, other proof of the child’s date of birth is required. • Disabled Child: Medical documentation showing the child is disabled and depends primarily on the Member for support (required at age 26). 	<ul style="list-style-type: none"> • Enroll in coverage • Change coverage tier • Enroll eligible dependents • Change to any available option for you + child(ren) or you +family • Enroll eligible dependents <p>Note: You have 90 days for a newborn</p>

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
Divorce	<p>Adding coverage for yourself</p> <ul style="list-style-type: none"> • Copy of divorce decree and loss of coverage documentation required • Furnish Social Security Number for each dependent you wish to cover <p>Removing a former spouse from coverage</p> <ul style="list-style-type: none"> • Copy of divorce decree 	<ul style="list-style-type: none"> • Enroll in coverage, if losing coverage through spouse's plan • Must remove spouse from coverage • Must remove step children from coverage • Change coverage tier • Enroll eligible dependents • Change coverage option to elect new coverage for you or you + child(ren)

If You Have One Of These Qualifying Events:

Provide This Documentation:

Within 31 Days Of Qualifying Event, You May / Must:

If a QMCSO requires:	You can:
You to provide coverage for your natural child(ren)	Enroll or change coverage tier – there is no time limit for this change; documentation of the court order is required
Your former spouse must provide coverage for each of your enrolled natural child(ren)	Change coverage tier; documentation of the court order and the other coverage is required
Spouse to provide coverage for his/her natural children Furnish Social Security Number and dependent verification documentation for each dependent you wish to cover	Enroll or change coverage tier – no time limit for this change; documentation of the court order requiring coverage is required

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
You or your spouse lose coverage through other employment	<ul style="list-style-type: none"> • Letter from other employer documenting loss of coverage and reason for loss is required • Furnish Social Security Number and dependent verification for each dependent you wish to cover 	<ul style="list-style-type: none"> • Enroll eligible dependent(s) • Enroll In Coverage • Change coverage tier • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family
You, your spouse, or enrolled dependent are covered under a qualified health plan and you lose eligibility, such as through other employment, Medicaid*, State Children’s Health Insurance Program (SCHIP) or Medicare	<ul style="list-style-type: none"> • Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation required 	<ul style="list-style-type: none"> • Change coverage tier • Enroll eligible dependent(s) • Enroll In Coverage • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family <p>* Note: For loss of Medicaid or SCHIP coverage, you have 60 days for actions above</p>
Loss of last dependent(s) that impacts your Tier	<ul style="list-style-type: none"> • Provide documentation stating the reason and date eligibility was lost unless the reason for loss of coverage is because of reaching age 26 	<ul style="list-style-type: none"> • Change coverage tier • Change coverage option to elect new coverage for you, or you + spouse, or you + child(ren),

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
<p>Your former spouse loses other qualified coverage, resulting in loss of your dependent child(ren)'s coverage under former spouse's plan</p>	<ul style="list-style-type: none"> • Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other plan documenting name(s), of everyone who lost coverage, date, reason, and when coverage was lost. 	<ul style="list-style-type: none"> • Enroll eligible dependent(s) • Enroll in Coverage for you and your eligible dependent(s) • Change coverage option to elect new coverage for you + child(ren) • Increase coverage tier
<p>Covered Dependent loses Eligibility</p> <ul style="list-style-type: none"> • Provide documentation stating the reason and date eligibility was lost unless the reason for loss of coverage is because of reaching age 26. 	<ul style="list-style-type: none"> • No documentation required to change coverage tier for last child who turns 26 	<ul style="list-style-type: none"> • Change coverage tier to remove ineligible spouse and/or dependent(s) • Change coverage option to elect new coverage for you, you + spouse, you + child(ren) or you + family
<p>Gain of coverage due to other employer's open enrollment</p> <p>Note: Plan year can be the same, but Open Enrollment dates must be different</p>	<ul style="list-style-type: none"> • Letter from other employer documenting name(s) of everyone who gained coverage, date, reason, and when coverage was gained 	<ul style="list-style-type: none"> • Change coverage tier to remove spouse and/or dependent(s) • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren) • Discontinue coverage
<p>Loss of coverage due to other employer's open enrollment</p> <p>Note: Plan year can be the same, but Open Enrollment dates must be different</p>	<ul style="list-style-type: none"> • Furnish Social Security Number for each dependent you wish to cover • Letter from other employer documenting name(s) of everyone who lost coverage, date, reason, and when coverage was lost 	<ul style="list-style-type: none"> • Enroll eligible dependent(s) • Enroll In Coverage • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family • Change coverage tier

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
<p>You or your spouse acquire new coverage under spouse's employer's plan</p>	<ul style="list-style-type: none"> • Letter from other plan documenting your effective date of coverage and names of covered dependents 	<ul style="list-style-type: none"> • Change tier to you coverage • Discontinue coverage – you must document that all members removed from the SHBP coverage are covered under the other employer's plan • Change coverage option to elect new coverage for you, or you + child(ren)
<p>Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan other than from SHBP</p>	<ul style="list-style-type: none"> • Letter from other employer documenting coverage enrollment required, and • Everyone removed from coverage under the SHBP must be enrolled in the plan. This includes coverage acquired due to the other employer's open enrollment. 	<ul style="list-style-type: none"> • Change coverage tier to remove spouse and/or dependent(s) • Change coverage option • Discontinue coverage
<p>You or your spouse is activated into military services</p>	<ul style="list-style-type: none"> • Furnish Social Security Number and dependent verification for each dependent you wish to cover • Copy of orders required 	<ul style="list-style-type: none"> • Enroll in coverage • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family • Change coverage tier • Discontinue coverage

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
<p>You retire and immediately qualify for a retirement annuity with any Georgia retirement system except, ERS, TRS, or PSERS</p>	<ul style="list-style-type: none"> You must complete and submit the Retiree Surviving Spouse form no later than 60 days after leaving active employment. Automatic deductions for health coverage should start when the retiree receives his/her initial retirement check. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check. 	<ul style="list-style-type: none"> Change coverage tier to you Change Option Discontinue Coverage
<p>Note: If your retirement system is ERS, TRS or PSERS you will automatically be enrolled in same option and tier as a retiree. You will receive a letter from SHBP advising you that the change was made and stating you have 31 days if you wish to make a change in coverage. However, if you and/or a covered dependent are enrolled in a minimum of Medicare Part B, coverage will roll over to the UHC Medicare Advantage (MA) Standard Option. The SHBP must have received and processed your Medicare information in order for the rollover to occur and have a street address as CMS will not approve enrollment in a MA option with a P. O. Box as your address. Please refer to the Medicare Section for more information.</p>		
<p>You retire and immediately qualify for a retirement annuity under the Georgia ERS, TRS, or PSERS retirement system</p>	<ul style="list-style-type: none"> Coverage will automatically roll if your retirement system is ERS, TRS or PSERS to the same option and tier you had as an active employee unless you have Medicare Part B coverage. Automatic deductions for health coverage only start when the Retiree receives his/her initial retirement check from ERS, TRS or PSERS. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check. <p>You should carefully read the Retiree Section, for additional important detailed information.</p>	<ul style="list-style-type: none"> Change coverage tier to you Change Option Discontinue Coverage

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
<p>Spouse's Loss of Eligibility for Health Insurance due to Retirement</p> <p>Note: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or a change in premiums ARE NOT qualifying events.</p>	<ul style="list-style-type: none"> Letter from other employer documenting loss of coverage, date coverage ended and reason for loss is required 	<ul style="list-style-type: none"> Change coverage tier Enroll eligible dependents Change coverage option to elect new coverage for you + spouse, or you + child(ren), or you + family
<p>If you choose to return to active service with an employing entity under the Plan, either immediately after you retire or at a later date, your retirement annuity may be suspended or continued but your health insurance must be through your active employment.</p>	<ul style="list-style-type: none"> You must complete the New Enrollment/Transfer Form 	<ul style="list-style-type: none"> You must elect SHBP coverage as an active employee.
<p>When you return to retiree status.</p>	<ul style="list-style-type: none"> You MUST complete the Retiree/Surviving Spouse Form to set up your deductions through the retirement system again 	<ul style="list-style-type: none"> Retiree coverage may be reinstated if you notify SHBP within 60 days. You must have continuous coverage, based on the conditions that first made you eligible as a retiree Change coverage tier to You Change Option

If You Have One Of These Qualifying Events:

Provide This Documentation:

Within 31 Days Of Qualifying Event, You May / Must:

You, or enrolled dependents turn age 65

- Required to submit proof of enrollment in Medicare. Enrollment in Medicare is not required while actively working. However, once retired, premiums and options are based on Medicare Advantage (MA) Enrollment. You must enroll in Medicare Part B and continue to pay Part B premiums to enroll in a SHBP MA Option. A copy of your Medicare card should be submitted the first of the month prior to the retirement month or month you turn 65.
- Additional rules apply when Medicare eligible. Please refer to the Retiree Section for more information.

As a Active Employee

- Change coverage tiers.
- If no eligible dependent(s) can discontinue coverage.

As a Retiree

- Discontinue your dependent(s) coverage. If you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage unless you return to work in a position that offers SHBP coverage.
- Retirees may change to any available option upon becoming eligible for Medicare coverage but you will lose the state's contribution toward your health coverage if you do not enroll in a Medicare Advantage option at age 65
- See the Retiree Section (#5) for more information.

How to Request a Change

During Open Enrollment and the Retiree Option Change Period, members can go online to make coverage changes for the upcoming Plan Year. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- **Notify your personnel/payroll office.** If you are retired, contact the SHBP Call Center directly at 404-656-6322 or 1-800-610-1863.
- **Return completed forms or make election on-line.** You must make your change by the appropriate deadline.

If you miss the deadline, you won't be able to make your change until the next Open Enrollment or Retiree Option Change Period, or if you experience a qualifying event. Changes permitted for retirees are limited, please refer to the retiree section for more details.

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends.

Events Ending Your Active Coverage

Coverage ends on the earliest of the dates specified in the following table:

Who:	Your Coverage Will End If:	When:
For You	<ul style="list-style-type: none"> • You no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased. • You do not make direct pay premium payments on time • You resign or otherwise your employment ends • You are laid off because of a formal plan to reduce staff • Your hours are reduced so that you are no longer benefits eligible • You do not return to active work after an approved unpaid leave of absence • You are terminated by your employer • Member contributions that are not remitted to the Plan by the due date may result in suspension/and or termination of coverage. • You intentionally misrepresent your response to surcharge questions. 	<ul style="list-style-type: none"> • Coverage for Member ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay. <p>Note: If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend benefit payments for Enrolled Members of the Employing Entity. Suspended coverage is not a COBRA event; however, the member may continue coverage if the member is eligible for continuation of coverage rights as defined in Section 9: Continuation of Coverage under COBRA Coverage will end at the end of the month following the month for which the last deductions were made for health insurance and submitted to SHBP.</p> <ul style="list-style-type: none"> • Coverage will end for 12 months beginning on the date that your false response is discovered

Who:

Your Coverage Will End If:

When:

When Coverage May Be Continued:

SHBP allows individuals to continue their SHBP coverage in certain situations when it would have otherwise ended.

-
- Leave your job with less than 8 years of services
 - Continue coverage for up to 18 months under COBRA provisions

-
- Leave your job and:
 - Have at least eight years of service but less than 10
 - Continue coverage by:
 - Submitting the Direct Pay Enrollment form within 60 days of when coverage would end
 - Pay full cost of coverage*
 - Provide statement from your employer verifying your service

*Except for participants covered under the Legislative Retirement System

-
- Leave your job and:
 - Have at least 10 years of service but before minimum age to qualify for an immediate retirement annuity
 - You leave money in retirement system
 - Continue coverage by:
 - Submitting the Direct Pay Enrollment form within 60 days of when coverage would end
 - Pay the full cost of coverage until your annuity begins (except for participants under the Legislative Retirement System)

(Information continued on next page)

Who:

Your Coverage Will End If:

When:

- Provide statement from your employer verifying your service
- Pay lower member premium once annuity begins if you have notified SHBP to start your deductions from your annuity

Note: The chart above applies for most SHBP members; certain parts of the Georgia code may stipulate other conditions for SHBP continuation. Member contributions not remitted to the Plan by the due date may result in suspension and/or termination of coverage.

For Your Dependents

- Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible.
- Coverage will end for children at age 26 unless disabled prior to age 26 and the appropriate documentation has been submitted and approved by SHBP

* A divorced spouse or covered dependent may continue Plan coverage by electing COBRA continuation coverage, which is limited to 36 months of coverage. The dependent must request COBRA coverage from the SHBP within 60 days of the qualifying event.

** **Discontinuation of coverage for a spouse or other covered dependent(s) during Open Enrollment does not qualify as a COBRA event. In order for a spouse or other dependent(s) to be eligible for continuation of coverage under COBRA, the SHBP must be notified at the time the divorce is final.**

Section 5: Provisions for Continuing Health Insurance as Eligible Retirees & Considerations for Members Near Retirement and Members with 8 or 10 Years of Service

(includes direct payees who will be eligible to draw an annuity at a future date)

Plan Membership

This section includes Plan Membership, Plan options and Medicare information for eligible retirees as well as important points to consider if you are near retirement. Currently, SHBP will pay primary benefits for retirees at 65 not enrolled in Medicare.

Enrollment in Medicare is not required while actively working. However, once retired, premiums and options change at age 65. You have two options:

- (1) If you enroll in Medicare Part B at age 65, you may enroll in one of the SHBP Medicare Advantage Option Standard or Premium Plans OR
- (2) You may have one of the other SHBP options, but you will not receive the state contribution toward the cost of your health insurance.

The HDHP option is not considered creditable coverage. This means:

If you do not enroll in a Medicare Advantage Option under SHBP when you first become eligible for Medicare (this plan includes Medicare Part D coverage) you will pay a penalty if you later enroll in a Medicare Advantage or individual Part D Plan after your initial enrollment period.

NOTE: Individuals who have lived at least 5 years in the United States may purchase Medicare Part B coverage even if they did not contribute to Social Security or work the number of required quarters. Enrollment in Medicare Part B is required to enroll in a MA Option

SHBP will continue to pay primary benefits for retirees not enrolled in Medicare at age 65 or older but the premiums will be much higher. See the Medicare COB section as there is important information you need to know.

Near Retirement

SHBP regulations allow a retiree to take into retirement the coverage that was in effect at the time of retirement. An active employee can pick up SHBP coverage and add dependents to the coverage during the Open Enrollment Period prior to retirement. The coverage will go into effect on January 1 of the following year and retirement will have to occur after January 1 for the election made during Open Enrollment to take effect.

Eligibility – to continue health insurance and draw an annuity

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these systems:

- Employees’ Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney’s Retirement System

Important Note: Individuals who withdraw all money from their respective retirement system will not be able to continue health coverage as a retiree. Eligibility for temporary extended coverage under COBRA provisions would apply.

If You Are:	Your Options as a Retiree:
If you and all covered dependents are under 65	<ul style="list-style-type: none"> • Options are the same as active employees • Premiums are like those of active employees • If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement

If You Are:	Your Options as a Retiree:
If you or a covered dependent have a minimum of Medicare Part B	<ul style="list-style-type: none"> • Choice of two Medicare Advantage (MA) Options Standard or Premium in addition to the HRA, HMO and HDHP options • If SHBP has received and processed your Medicare Part B information, SHBP will roll your coverage to the MA Standard under your current healthcare vendor. SHBP contributes to the cost of healthcare premiums for retirees who enroll in one of the MA options only. • If you have dependents not eligible for the MA option, their coverage will roll to the option they had at the time the member became covered by the MA option. • You must continue to pay your Medicare Part B premium to remain eligible for a MA option. Failure to pay Part B premiums may result in the loss of SHBP coverage

If You Are:	Your Options as a Retiree:
	<ul style="list-style-type: none"> • MA includes Medicare Parts A, B and D and does not coordinate benefits with Medicare • If you elect to enroll in the HRA, HMO or HDHP option, you will pay the total premium. Medicare will be primary and SHBP will coordinate benefits with Medicare • If you are enrolled in a SHBP MA option and enroll in an individual MA Plan or Part D Plan, you will lose your SHBP coverage
<p>Note: The HDHP Plan is not a creditable plan for your Medicare prescription drug coverage. Enrollment in the HDHP may result in you having a penalty applied to your Medicare premium. Please refer to the HDHP Summary Plan Description for details. This penalty will apply each month whether you are in the Medicare Advantage Plan or an individual Part D Plan. SHBP Medicare Advantage Plans include Part D prescription drug coverage. SHBP will be primary if you do not have Medicare coverage. There will be no adjustments in premiums because you have other coverage such as TRICARE, VA or other group coverage since SHBP may have potential primary liability.</p>	

IMPORTANT SPECIAL NOTE

Eight Years of Service but less than 10

The State Health Benefit Plan allows individuals to continue their health insurance by paying the full premium after their active employment ends if they have a minimum of 8 years of service – **(you are not eligible for an annuity).**

Minimum of 10 Years of Service

If you have a minimum of 10 years of service, your premium may be reduced once you start drawing your annuity if you notify SHBP when your annuity payments begin and your health insurance premiums are deducted from your annuity. It is your responsibility to notify SHBP to change your health deduction from direct pay to withholding from the retirement benefit once your annuity is started. You will not receive the lower premium until SHBP is notified and no refund will be given. You should verify with the retirement system that they have started your health deduction.

Applying for Coverage Continuation

If you are an eligible retiree, you must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your active coverage ends. Application can be made on a *Retirement Surviving Spouse Form*, available online at www.dch.georgia.gov/shbp **under forms** or by contacting the Plan's Eligibility Section. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.** Members of ERS, TRS, and PSERS will be automatically enrolled in the same option they had as an active employee, unless Medicare Part B coverage has been reported to SHBP. Retirees with Medicare Part B coverage on file will automatically be enrolled in the Medicare Advantage Standard Option under the healthcare vendor they currently have.

SHBP contributes to the cost of healthcare premiums for retirees who enroll in one of the Medicare Advantage options only.

Retirees may request to change options if the request is made within 31 days of retirement. You may request the change by downloading, printing and completing the Retiree/Surviving Spouse Form available online at www.dch.georgia.gov/shbp or you may call the SHBP Call Center at (800) 610-1863 or (404) 656-6322 to request a form. Plan options include the Medicare Advantage Premium Plan, High Deductible Health Plan (HDHP), Health Maintenance Organization (HMO), and Health Reimbursement Account (HRA). If you or coverage dependent are age 65 or older and elect to enroll in one of the non-MA options, you will not receive the State contribution toward the cost of your premiums.

Note: The HDHP Plan is not a creditable plan for your Medicare prescription drug coverage. Enrollment in the HDHP may result in you having a penalty applied to your Medicare premium. Please refer to the HDHP Summary Plan Description for details. You should not; however, enroll in Medicare Part D if you will be enrolling in one of the SHBP Medicare Advantage Options.

When Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage starts immediately at retirement, provided that you make proper premium payments or have them deducted from your retirement check. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your retiree coverage begins. A change from You to You + Spouse, You + Child(ren) or You + Family as a retiree is allowed only when you have a qualifying event.

Note: If you discontinue coverage at the time you retire or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.

When May My Coverage End?

For You

- My coverage may end if I choose to cancel my coverage
- My coverage may end if I am paying SHBP direct for my premiums and I stop paying
- My coverage may end if I purposely answer the surcharge questions incorrectly so that I do not have to pay the surcharge penalties

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- If Social Security Number is not provided
- You change from family to You coverage
- You do not pay premiums on time
- Your coverage as a Member ends

Keep in mind that if dependents are dropped from your coverage, you will not be able to enroll them again – unless you have a qualifying event.

Note: CMS does not allow enrollment in more than one Medicare Advantage plan. Enrollment in another MA or Part D plan may result in loss of SHBP coverage.

Continuing Dependent Coverage at Your Death

In the event of your death, your covered surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc.) and the Plan as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse Form and send it to the Plan within 60 days of your death.

Plan provisions vary for survivors:

Surviving spouse receives annuity

- Plan coverage may continue after your death
- Premiums will be deducted from annuity
- Spouse sends payments directly to Plan if annuity is not large enough to cover premium
- New dependents or spouse *cannot* be added to survivor's coverage
- Surviving spouse who becomes eligible for SHBP coverage as an active employee must discontinue the surviving spouse coverage and enroll as an active employee.
- When you return to a surviving spouse status, surviving spouse coverage may be reinstated after notifying the Plan within 31 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a surviving spouse.

Surviving spouse does not receive annuity

- Plan coverage may continue after your death if spouse was married to you at least one year before death
- Spouse sends payments directly to the Plan
- Coverage ends if surviving spouse remarries

Surviving child does not receive annuity and there is no surviving spouse

- Plan coverage may continue under COBRA provisions

See Section 9 for details.

Making Changes to Your Retiree Coverage

You can make changes to your coverage tier only at these times:

- Within 31 days of a qualifying event
 - You may add a dependent as long as the change is consistent with the qualifying event
 - You have 90 days to add a newborn
- During the annual Retiree Option Change Period
 - You may change your Plan option only
 - Adding dependents is not permitted during Annual Retiree Option Change Period (AROCP) unless you have a qualifying event as described in the section below.

If you and your dependents enroll in the UHC Medicare Advantage PPO (MA PPO) option, any dependents not eligible for MA PPO option will be covered under the option they had at the time the member became covered by the MA Option.

Dropping Your Retiree Coverage

You can drop coverage or change to “You” only coverage at any time. However, if you drop SHBP coverage you will not be able to get the coverage back unless you return to work in a position that offers SHBP coverage.

Qualifying Events

Examples of a qualifying event are getting married, having a baby, spouse loses eligibility for health insurance. If you experience a qualifying event, you must request a coverage change within 31 days of the qualifying event (90 days for a newborn) by:

- Contacting the Plan directly
- Returning the necessary form(s) with any requested documentation and the dependent's Social Security Number (SSN) to the Plan by the deadline.

* Fill out the form(s) completely. The Centers of Medicare and Medicaid Services (CMS) require SHBP to capture the SSN for all dependents. SHBP will provide coverage for a dependent to age two without a SSN.

If you miss the deadline, you will not have another chance to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request, unless indicated in the chart below.

*** Do not hold form requesting change even if you are waiting on documentation. Request must be made within 31 days of qualifying event.**

If you have this qualifying event...	You may...
<p>You retire and immediately qualify for a retirement annuity with any Georgia retirement system</p> <p>Coverage must be continuous from active to retiree status.</p>	<ul style="list-style-type: none"> • You must complete and submit the Retiree Surviving Spouse Enrollment form no later than 60 days after leaving active employment unless you are in one of the retirement systems listed below • Your coverage will automatically roll from active to retiree status if in ERS, TRS, or PSERS • Change coverage tier to You, You + Spouse, or You + Child(ren) • Change to any available Option • Discontinue Coverage

(Information continued on next page)

If you have this qualifying event...

You may...

If your retirement check through the State of Georgia no longer covers the premium for your health coverage

- You will be changed to a direct pay status and the premium will include a \$5.00 administrative fee. You will pay SHBP monthly for your health coverage.

- Change to any available Option
- Drop coverage
- Lower coverage tier to You, You + Spouse, or You + Child(ren)
- Change to Medicare Standard or Premium Plan

You or dependent turn 65

- You will be rolled into the Medicare Advantage Standard Plan with UHC if SHBP has received and processed a copy of your Medicare Part B enrollment.

Enrollment in Medicare is not required while actively working. However, once retired premiums and options are based on Medicare Part B enrollment. A copy of your Medicare card(s) should be submitted the first of the month prior to the retirement month or the month you or your spouse reach age 65. Enrollment in Medicare Part B is necessary to enroll in a Medicare Advantage option. You must continue to pay your Part B premiums to keep your Medicare Advantage coverage.

- Change to Medicare Advantage Premium Plan
- Change to any available option, but you will lose the state contribution toward your premium

Note: If your mailing address in SHBP records is a PO Box, CMS will not approve your enrollment into a MA Plan. You will remain in your current option without state contribution until you provide a Street Address and CMS approves your enrollment into a MA plan.

If you have this qualifying event...

You may...

If you are working in a benefits eligible position and are continuing to receive your retirement annuity

- You must advise SHBP when you terminate your benefits eligible position or you will not have health coverage as a retiree. You will need to complete the Retiree Surviving Spouse form to have your health insurance deductions taken out of your retirement check.

- You must have coverage as an active employee
- You must follow the active coverage rules as long as you are working in a SHBP benefits eligible position

Note: Once you terminate your SHBP benefits eligible position you must follow the plan rules for retirees

Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO)

- Within 31 days of qualifying event (90 days for a newborn)

- Change coverage tier
- Change coverage option
- Add your eligible dependent(s)

Spouse's loss of eligibility for health insurance due to retirement

Note: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or change in premiums ARE NOT qualifying events. Loss of eligibility for health insurance at retirement is a qualifying event.

- Within 31 days of qualifying event
- Provide a letter from the other plan documenting loss of coverage and reason for loss is required. You will need to furnish the Social Security Number for each dependent you wish to cover.

- Change coverage tier
- Change coverage option
- Add your eligible spouse

If you have this qualifying event...	You may...
Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	<ul style="list-style-type: none"> • Within 31 days of qualifying event • Change coverage tier • Change coverage option • Add your eligible dependent(s) • A letter from the other plan documenting loss/gain of coverage (reason for loss of coverage is required.) You will need to furnish the Social Security Number for each dependent you wish to cover.
Divorce	<ul style="list-style-type: none"> • Must remove spouse from coverage • Must remove stepchildren from coverage • Change coverage tier • Change coverage Option to any available Option
You and spouse are both retirees and each have sufficient retirement benefits from a State of Georgia covered retirement system to have Plan premiums deducted	<ul style="list-style-type: none"> • Change at any time from family coverage to each having You only coverage; a request to change from family to You only for you and your spouse must be filed at the same time.
Loss of dependent(s) that impacts your Tier (i.e. loss of all eligible dependents – you may change tiers to You coverage)	<ul style="list-style-type: none"> • Loss of dependent that effects your current tier • Change coverage tier

Changes Permitted Without A Qualifying Event

Retirees may change to lower tier or discontinue coverage at anytime by submitting the Retiree Surviving Spouse form. However, if you change tiers you cannot increase your coverage later without a qualifying event. **If you discontinue coverage, you may not enroll later unless you return to work in a State of Georgia benefit eligible position.**

Important Note On Coverage Changes: If your current Plan option is not offered in the upcoming Plan year and you do not elect a different option available to you during the Retiree Option Change Period, your coverage will be transferred automatically to an option selected by SHBP effective January 1 of the subsequent Plan year.

Retiree Option Change Period

During the 30-day Retiree Option Change Period, generally from mid-October to mid-November each Plan year, you can make these changes to your coverage:

- Select a new coverage option
- Change to a lower tier
- Discontinue coverage (**Note:** Re-enrollments are not allowed.)

Changes will take effect the following January 1.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options
- Steps for notifying the Plan about coverage selections for the new Plan year

- Forms you may need to complete
- Informational resources.

To ensure that you receive the information packet, make sure the SHBP always has your most up to date mailing address. Mail letter notifying SHBP of new address to: SHBP, P. O. Box 1990, Atlanta, GA 30301-1990. Be sure to include the retiree's Social Security Number.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an active employee with payroll deduction by your employer. You will need to complete enrollment paperwork with your employer and verify the deduction stopped with the retirement system.

When you return to retired status, retiree coverage will only be reinstated after notifying the Plan within 31 days if you have continued to receive your retirement annuity. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to retiree Plan coverage unless the final service period qualifies you for a retirement benefit from a state supported retirement system.

Special Note: Re-enrollment into retiree coverage is not automatic if you continued to receive your retirement check. You must request retiree coverage within 31 days of loss of active coverage or you will lose eligibility for retiree coverage.

Medicare Coordination of Benefits for Health Reimbursement Account (HRA), High Deductible Health Plan (HDHP) and Health Maintenance Organization (HMO)

Coordination of Benefits with Medicare

To prevent duplicate benefit payment, the Plan coordinates benefits with Medicare and any other plan that may cover you and your dependents. The first step in coordination is the determination of which plan is primary or which plan pays benefits first and which plan is secondary. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits.

The chart below provides important details related to primary and secondary coverage based on your Medicare status (for you and/or your dependents who are not enrolled in a Medicare Advantage plan):

If you are retired and...	The Plan will pay...
<ul style="list-style-type: none"> ...age 65, consider enrolling in Medicare Parts A, B, and D two months prior to the month in which you turn 65 to maximize coverage 	<ul style="list-style-type: none"> Secondary benefits starting on the first day of the month in which you turn 65
<ul style="list-style-type: none"> ...age 65, Medicare eligible and do not enroll in Part A, Part B and Part D 	<ul style="list-style-type: none"> Primary benefits; however, Plan premium will increase significantly

If you are retired and...	The Plan will pay...
<ul style="list-style-type: none"> ...age 65 or older and not entitled to Medicare (because have not lived in the U.S. for 5 years or longer) 	<ul style="list-style-type: none"> Primary benefits; however, Plan premium will increase significantly
<ul style="list-style-type: none"> ...age 65 or older and have dependents not entitled to Medicare because of age 	<ul style="list-style-type: none"> Primary benefits for dependents

The SHBP is not a supplemental plan to Medicare. The Plan will pay secondary benefits/coordinate benefits if retired and enrolled in Medicare and the HRA, HDHP, or HMO Option. The Plan does not pay secondary benefits with the Medicare Advantage Options.

Frequently asked Medicare Questions

- Are you not yet eligible for Medicare?
 - You may elect to have coverage under any of the non-Medicare plan options offered by SHBP.
 - Your health premiums will be very similar to those of active employees
- Are you eligible or about to be eligible for Medicare?
 - Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. Medicare becomes your primary insurance carrier once you are covered by Medicare. You are eligible for Medicare even if you never

paid into Social Security. You and/or your spouse can purchase Medicare Part B if you are a U.S. Citizen, reside in the U.S., age 65 or older (or a legal non-citizen, age 65 or older, who resides and has lived in the U.S. for at least 5 years or longer)

- You will need to send a copy of your Medicare coverage (A, B or D) to SHBP at P.O. Box 1990, Atlanta, GA 30301-1990 the first of the month prior to the month in which the retiree turns 65 or becomes eligible for Medicare because of disability. Options and premiums cannot be adjusted until copies of your Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information does not qualify for a refund of the difference in premiums.

Medicare information is available at:

- www.cms.hhs.gov/medicarerereform
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)

Due to Disability

- If you are disabled under Social Security, you may qualify for Medicare after a waiting period

3. What if I have End Stage Renal Disease?

- If you or your dependents are enrolled in Medicare due to End Stage Renal Disease (ESRD), you may not enroll in a Medicare Advantage option during your first 30 months of Medicare coverage because SHBP is your primary coverage. After 30 months, when Medicare becomes primary, you may enroll in one of the Medicare Advantage plans. You will need to send the SHBP a copy of the letter from Social Security advising of Medicare eligibility

Section 6: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Contracted provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Contracted provider, you are responsible for filing a claim and payment.

If You Receive Covered Health Services from a Contracted provider

We pay Contracted providers directly for your Covered Health Services. If a Contracted provider bills you for any Covered Health Service, contact UnitedHealthcare. However, you are responsible for meeting the Annual Deductible and for paying Copayment/Coinsurance to a Contracted provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Contracted provider:

You must submit a request for payment of Benefits within 24 months following the month of service. If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the month of service is the date your Inpatient Stay ends.

Claim forms may be obtained from myuhc.com or by contacting customer service.

Medicare Part D Information

Note: You should not enroll in a Part D plan if you are enrolled in a SHBP Medicare Advantage option as this will terminate your SHBP coverage.

If you are not enrolled in Medicare Part D, you may enroll during the Medicare annual open enrollment, November 15 - December 31. This open enrollment is held by the Centers for Medicare and Medicaid (CMS) and not by SHBP. In many cases, you do not need the enhanced prescription drug plan. Your individual pharmacy needs will indicate the level of coverage that is best for you.

Part D enrollment is only for those Medicare eligible enrollees who wish to be enrolled in one of the SHBP options that do not receive the state contribution toward the cost of health insurance: High Deductible Health Plan (HDHP), Health Maintenance Organization (HMO), and Health Reimbursement Account (HRA). You should not enroll in a Part D plan if you are enrolled in a SHBP Medicare Advantage option as this will terminate your SHBP coverage.

Coordination of Pharmacy Benefits between your Prescription Drug Plan (PDP) 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 Medicare coordination of benefits occurs, you should not be responsible for more than your SHBP copayment for eligible charges.
- When you reach the PDP coverage gap, you should still present both identification cards and you will pay your SHBP copayment.
- Please note in order 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 progression Rx receive approval before your claims may be considered for reimbursement.

Required Information

When you request payment of Benefits from us, you must provide all of the following information:

- A. Member's name and address.
- B. The patient's name, age and relationship to the Member.
- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
 - Patient diagnosis
 - Date of service
 - Procedure code(s) and description of service(s) rendered
 - Provider of service (Name, Address and Tax Identification Number)

- E. The date the Injury or Sickness began.
- F. 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 of the other carrier(s).

Payment of Benefits

Through UnitedHealthcare, we will make a benefit determination as set forth below.

You may assign your Benefits under the Plan to a non-Contracted provider.

UnitedHealthcare will notify you if additional information is needed to process the claim. UnitedHealthcare may request a one time extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

UnitedHealthcare will notify you within this 30-day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, UnitedHealthcare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving the requested medical care. If your claim is a pre-service claim, and is submitted properly with all needed information, you will receive written notice of the pre-service claim decision from UnitedHealthcare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UnitedHealthcare will notify you of the pre-determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these 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 24 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, UnitedHealthcare will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- UnitedHealthcare's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

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.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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 claim and decided according to post-service or pre-service timeframes, whichever applies.

Section 7: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

United HealthCare Services, Inc.
PO Box 30994
Salt Lake City, Utah 84130-0994

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 Customer Service before requesting a formal appeal. If the Customer 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 Section 6: How to File a Claim you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of UnitedHealthcare.

If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call.

How to Appeal a Claim Decision

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.

Appeal Process – How to Appeal an Eligibility Decision

The SHBP will handle all eligibility appeals. There are three steps in the appeal process:

STEP 1 – TELEPHONE REVIEW

Call the SHBP's eligibility unit and ask for a review within 90 days of the eligibility denial. If you disagree with the results of the review, you may file a written request for an Administrative Review. Contact the Eligibility Unit within 90 days of when the Plan advises you that your request cannot be approved.

Note: Any issue regarding the Plan's eligibility or participation should first be addressed to the Eligibility Unit and then through the Administrative Review process.

STEP II – ADMINISTRATIVE REVIEW

To file a request for Administrative Review, complete all applicable Sections on the Admin Review form, sign the form and send a copy of the denied action if applicable. Any additional facts or materials that are pertinent to the case should be attached and submitted with this form within 90 days of the denied action concerning your eligibility. Generally a decision is reached within 60 days of receipt unless additional information is needed.

STEP III – FORMAL APPEAL

If your request for Administrative Review is denied, you may file a Formal Appeal, which must be postmarked within 60 days following the date of the Administrative Review decision. To file a Formal Appeal, you must complete the applicable form and attach a copy of the decision of the Administrative Review. Instructions are on the Formal Appeal form. Generally a decision is issued within 90 days following receipt; however, the number of days may be extended by notice from the SHBP. 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 Eligibility Administrative Reviews and Formal Appeals along with a completed appeal form to: State Health Benefit Plan, Vendor Program Management Unit, P. O. Box 1990, Atlanta, GA 30301. The appeal forms are available through your Personnel/Payroll office, website address www.dch.georgia.gov/shbp or directly from the SHBP. All member correspondence sent to the Plan should include the enrolled member's Social Security Number (SSN) to prevent a delay in processing your request.

Appeals Determinations

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 6: How to File a Claim, 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 6: How to File a Claim, 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" below.

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.

For pre-service and post-service claim appeals, SHBP have delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the Plan. UnitedHealthcare's decisions are conclusive and binding.

Note: 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.

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 24 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the Plan. UnitedHealthcare's decisions are conclusive and binding.

Voluntary External Review Program

If, after exhausting the two levels of appeal, 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 or Investigational Services 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 UnitedHealthcare at the toll-free number on your ID card for more information.

Section 8: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Filing a Claim When Coordination of Benefits (COB) applies

You and your Covered dependents may have medical coverage under more than one 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 member'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 member is responsible for any remaining balance including co-payments. 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 Member'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 24-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 *Subrogation*.

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 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 Member 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:** Members 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. Retirees should refer to the Retiree Section 5 for additional information.

*** Note** for Retirees with primary coverage through Medicare: Network providers may collect the office visits Copayment at the time of service.

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 Member 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 Member (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 can not 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.

Section 9: Continuation of Coverage under COBRA

This section provides you with information about all of the following:

- Continuation of coverage under federal law (COBRA).

When Coverage may be Continued

Certain situations allow you to continue your SHBP coverage.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or longer for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience

- Family medical reasons as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation which you will supply to your employer.

You can apply for continued coverage within 31 days after starting an unpaid leave.

Continuing Coverage during Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	You will be affected in this way:
<ul style="list-style-type: none"> • You are Totally Disabled and are on an approved disability leave <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work 	<ul style="list-style-type: none"> • You will be eligible to continue health benefits for up to 12 months • You must pay premiums directly to your employer • Coverage is limited to whichever is less: <ul style="list-style-type: none"> — The disability period that your Physician certifies. You must provide additional documentation of your disability period to your employer

If you are a disabled retired Member, see Provisions for Eligible Retirees for more information on how your coverage may be affected.

Continuing Coverage under Family and Medical Leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks for specific medical and/or family medical reasons. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, premium payment is made directly to your employer. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation:	You will be affected this way:
<ul style="list-style-type: none"> • Choose not to continue coverage while on leave 	<ul style="list-style-type: none"> • Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers. • You must resume coverage when you return to work.
<ul style="list-style-type: none"> • Open Enrollment period occurs while on leave 	<ul style="list-style-type: none"> • If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment • If you do not continue coverage while on leave, contact your employer for Open Enrollment information

If you have this situation:	You will be affected this way:
<ul style="list-style-type: none"> Do not return to work after your leave ends and you have paid your premiums directly to your employer during your leave 	<ul style="list-style-type: none"> You may be eligible to continue your medical coverage through COBRA

Continuing Coverage during Military Leave

You and your dependents have the right to continue your coverage with premium payments sent directly to your employer.

- If you are an activated military reservist called on an emergency basis, you will pay your employee share of the premium.
- For other military leaves, you will be required to pay the full premium.

You may elect to discontinue coverage while on leave. The SHBP will reinstate your coverage when you return from military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Member's illness or injury that the Secretary of Veterans' Affairs determined was acquired or aggravated during the military leave.

If You Leave Your Job

This chart shows how your coverage would be affected if you were to leave your job:

If you have this situation:	You will be affected in this way:
<ul style="list-style-type: none"> Leave your job with less than eight years of service Take another job that does not qualify you for coverage Move to part-time status Are laid off 	<ul style="list-style-type: none"> You can continue coverage for up to 18 months under COBRA provisions
<p>Leave your job and:</p> <ul style="list-style-type: none"> Have at least eight years of service, but less than 10 years 	<p>You can continue coverage by:</p> <ul style="list-style-type: none"> Submitting the Direct Pay Enrollment forms within 60 days of when your coverage would end Paying the full cost of coverage, except Subscribers under the Legislative Retirement System Providing a statement from your employer verifying your service

If you have this situation:	You will be affected in this way:
<p>Leave your job and:</p> <ul style="list-style-type: none"> • Have at least 10 years of service, but before minimum age to qualify for an immediate retirement annuity • You leave money in retirement system 	<p>You can continue coverage by:</p> <ul style="list-style-type: none"> • Submitting the Retiree Surviving Spouse Form within 60 days of when your coverage would end • Paying the full cost of coverage until your retirement check begins • Paying a lower Member premium once your retirement check begins

See provisions for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

In the Event of an Active Employee's Death

The benefits available to your survivors will depend on your length of service.

- When your surviving spouse receives a monthly check from a qualifying retirement system, your covered survivor(s) can continue Plan coverage if your surviving spouse:
 - Elects to receive his or her benefits as a monthly check (versus a lump-sum benefit)
 - Sends the Plan a Retiree/Surviving Spouse Form within 90 days after your death

Surviving children can continue coverage until they are ineligible under Plan rules. Dependents may not be added after your death.

- When your surviving spouse does not receive your monthly retirement check or when a lump-sum benefit is elected, your survivor(s) can continue coverage through COBRA

See provisions for Eligible Retirees for information on survivor coverage in the event of a retiree's death.

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Member.
- A Member's Enrolled children, step-children, or legal child.
- A Member's former spouse.
- A Member's covered spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of the Member from employment with us, for any reason other than gross misconduct, or reduction of hours; or
- B. Death of the Member; or

- C. Divorce of the Member; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or
- E. Entitlement of the Member to Medicare benefits; or
- F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Member and his or her Enrolled Dependents. This is also a qualifying event for any retired Member and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Member or other Qualified Beneficiary must notify SHBP within 60 days of the Member's divorce or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Member or other Qualified Beneficiary fails to notify SHBP of these events within the 60 day period, SHBP is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Member is continuing coverage under Federal Law, the Member must notify SHBP within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

Notification Requirements for Disability Determination or Change in Disability Status

The Member or other Qualified Beneficiary must notify SHBP as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to SHBP at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that SHBP is able to determine the covered employee and Qualified

Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Member or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to SHBP, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

The Qualified Beneficiary's initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact SHBP for additional information. The Member must contact SHBP promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Member's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to

the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Member, divorce of the Member, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).
- C. For the Enrolled Dependents of a Member who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Member's Medicare entitlement.
- D. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated

because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Plan ends.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Member dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Member's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Member becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact SHBP for information regarding the continuation period.

Section 10: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description presents an overview of your benefits. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all time.

Relationship with Providers

The relationships between SHBP, UnitedHealthcare, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees; nor are they agents or employees of UnitedHealthcare. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of UnitedHealthcare; nor do we have any other relationship with Network providers such

as principal agent or joint venture. Neither we nor UnitedHealthcare are liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan.

We and the UnitedHealthcare are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Plan Sponsor and employee, Dependent or other classification as defined in the Plan.

Incentives to You

Sometimes UnitedHealthcare may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact UnitedHealthcare if you have any questions.

Interpretation of Benefits

SHBP and UnitedHealthcare have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

SHBP and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverage's or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including UnitedHealthcare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or UnitedHealthcare may need additional information from you. You agree to furnish us and/or UnitedHealthcare with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or UnitedHealthcare with all information or copies of records relating to the services provided to you. We or 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 Member's enrollment form. We and UnitedHealthcare agree that such information and records will be considered confidential.

We and 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 we are required to do by law or regulation. During and after the term of the Plan, we, UnitedHealthcare, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you 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 us, we 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.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you.

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.

Refund of Overpayments

If we pay 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 us if either of the following apply:

- 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 we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us 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, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us 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 us or UnitedHealthcare.

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

Section 11: Your Rights and Responsibilities

Employee Rights and Responsibilities

Your Rights as an Employee Enrolled in Plan Coverage

As an employee 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

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your COBRA continuation coverage rights.

Your Responsibilities as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

- **Make proper and timely premium payments.** Premium payments usually are made through convenient payroll deduction. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage tier. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information.
- **Make accurate choices when you make your enrollment selection.** After the Open Enrollment period ends, the SHBP will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Member that the Plan had no liability for additional covered persons.

- **Take the time to understand how the 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 *Health Plan Decision Guide*. Having read the documents, you can take steps to maximize your coverage.
- **Know when and how your participation can end.** Generally, coverage ends when you no longer meet job classification or working hours requirements for eligibility or when you fail to make the proper premium payments. For eligibility requirements and other circumstances that may result in loss of coverage, see sections 4 & 5.
- **Notify the SHBP office of any address changes. Notify the Plan if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify your payroll location within 31 days (90 days for a newborn) of the event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status (90 days for a newborn) could permanently prohibit a retiree from making the desired change.
- **Furnish the Plan with information required to implement Plan provisions.** You are required to provide any information and documentation that the Plan needs to carry out its provisions. If you do not make this request within 31 days of the qualifying event, your request for benefits or Plan membership will be denied.
- **SHBP will allow members to submit verification of their dependent's eligibility any time during the Plan Year.** However, no claims will be paid until the documentation is received and approved by SHBP. Coverage will be effective the first of the month that the qualifying event occurred.
- **Update the Plan on the status of eligible dependents.** If your dependent child is nearing age 26, and is eligible to continue coverage as a disabled dependent you are responsible for informing the Plan of his or her status within 31 days of reaching age 26. Coverage won't continue automatically after a disabled dependent turns 26 – you must request it.
- **Notify the Plan of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which includes the following:

- Submit any necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with the bill to the Plan when due. If your employer does not send in premiums and documentation in a proper and timely manner, the Plan may suspend coverage benefit payments for the Employee.
- Assist in enrolling all eligible full-time employees in the Plan within 31 days of hire unless the employee declines coverage. Then the declination form must be completed within 31 days of hire.
- Provide enrollment information to the Plan Administrator.
- Distribute Plan materials.

- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Administer Leave without Pay for employees.
- Provide you with information on how you can continue coverage under the FMLA and under state leave without pay provisions.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 404-656-6322 in Atlanta, or at 800-610-1863 outside of Atlanta.

Retiree Rights and Responsibilities

Your Rights as a Retiree Enrolled in Plan Coverage

As a retiree 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

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your COBRA continuation coverage rights.

Your Responsibilities as a Retiree Enrolled in Plan Coverage

As a retiree enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

- **Make proper and timely premium payments.** Premium payments usually are made through 1) the state retirement system for retirees who receive an annuity or 2) by paying directly to SHBP.
- **Take the time to understand how the 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 *Retiree Health Plan Decision Guide*. Having read the documents, you can take steps to maximize your coverage.

- **Notify SHBP of any address change including a street address for members turning 65 where the mailing address is a P. O. Box.**
- **Notify the Plan within 31 days if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days (90 days for a newborn) of a qualified change in status could permanently prohibit a retiree from making the desired change.
- **Furnish the Plan with information required to implement Plan provisions.** You are required to provide any information and documentation that the Plan needs to carry out its provisions. If you do not make the request within 31 days of the qualifying event (90 days for a newborn), your request for benefits or Plan membership will be denied.
- **SHBP will allow members to submit verification of their dependent's eligibility any time during the Plan Year.** However, no claims will be paid until the documentation is received and approved by SHBP. Coverage will be effective the first day of the month that the qualifying event occurred.
- **Notify the Plan of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 404-656-6322 in Atlanta, or at 800-610-1863 outside of Atlanta.



Section 12: Department of Community Health Privacy Notice

State Health Benefit Plan Information Privacy Notice

Revised March 23, 2010.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Questions? Call 404-656-6322 (Atlanta) or 800-610-1863 (outside of Atlanta).

The DCH and the State Health Benefit Plan Are Committed to Your Privacy. The Georgia Department of Community Health (DCH) sponsors and runs the State Health Benefit Plan (the Plan). We understand that your information is personal and private. Some DCH employees and companies hired by DCH collect your information to run the Plan. The information is called “Protected Health Information” or “PHI.” This notice tells how your PHI is used and shared. We follow the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, (“HIPAA”).

Only Summary Information is Used When Developing and Changing the Plan. The Board of Community Health and the Commissioner of the DCH make decisions about the Plan. When making decisions, they review reports. These reports explain costs, problems, and needs of the Plan. These reports never include information that identifies any person. If your employer is allowed to leave the Plan, your employer may also get summary reports.

Plan Enrollment Information and Claims Information is Used in Order to Run the Plan. PHI includes two kinds of information. “Enrollment Information” includes: 1) your name, address, and social security number; 2) your enrollment choices; 3) how much you have paid in premiums; and 4) other insurance you have. This Enrollment Information is the only kind of PHI your employer is allowed to see. “Claims Information” includes information your health care providers send to the Plan. For example, it may include bills, diagnoses, statements, x-rays or lab test results. It also includes information you send to the Plan. For example, it may include your health questionnaires, enrollment forms, leave forms, letters and telephone calls. Lastly, it includes information about you that is created by the Plan. For example, it includes payment statements and checks to your health care providers.

Your PHI is Protected by Law. Employees of the DCH and employees of outside companies hired by DCH to run the Plan are “Plan Representatives.” They must protect your PHI. They may only use it as allowed by HIPAA.

The DCH Must Make Sure the Plan Complies with HIPAA. As Plan sponsor, the DCH must make sure the Plan complies with HIPAA. We must give you this notice. We must follow its terms. We must update it as needed. The DCH is the employer of some Plan Members. The DCH must name the DCH employees who are Plan Representatives. No DCH employee is ever allowed to use PHI for employment decisions.

Plan Representatives Regularly Use and Share your PHI in Order to Pay Claims and Run the Plan. Plan Representatives use and share your PHI for payment purposes and to run the Plan. For example, they make sure you are allowed to be in the Plan. They decide how much the Plan should pay your health care provider. They also use PHI to help set premiums for the Plan and manage costs but they are never use genetic information for these purposes. Some Plan Representatives work for outside companies. By law, these companies must protect your PHI. They also must sign “Business Associate” agreements with the Plan. Here are some examples what they do.

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra help to Members with some health conditions.

Data Analysis, Actuarial Companies: Keep health information in computer systems, study it, and create reports from it.

Attorney General's Office, Auditing Companies, Outside Law Firms: Provide legal and auditing help to the Plan.

Information Technology Companies: Help improve and check on the DCH information systems used to run the Plan.

Some Plan Representatives work for the DCH. By law, all employees of the DCH must protect PHI. They also must get special privacy training. They only use the information they need to do their work. Plan Representatives in the SHBP Division work full-time running the Plan. They use and share PHI with each other and with Business Associates in order to help pay claims and run the Plan. In general, they can see your Enrollment Information and the information you give the Plan. A few can see Claims Information. DCH employees outside of the SHBP Division do not see Enrollment Information on a daily basis. They may use Claims Information for payment purposes and to run the Plan.

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special times when the Plan may use or share your PHI without your authorization. At these times, the Plan must keep track of the use or disclosure.

To Comply 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.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities. For example, the Plan may give PHI to DCH employees in the Public Health Division who need it to do their jobs.

For Research Purposes: Your PHI may be given to researchers for a research project approved by a review board. The 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 with your legal personal representative. However, the Plan may inform the employee family member about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. You may give a written authorization for the Plan to use or share your PHI for a reason not listed in this notice. If you do, you may take away the authorization later by writing to the

contact below. The old authorization will not be valid after the date you take it away.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to See and Get a Copy your Information, Right to Ask for a Correction: Except for some reasons listed in HIPAA, you have the right to see and get a copy of information used to make decisions about you. If you think it is incorrect or incomplete, you may ask the Plan to correct it.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of special uses and disclosures that were made after April, 2003.

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. You also may ask the Plan to communicate with you in a special way.

Right to a Paper Copy of this Notice, Right to File a Complaint Without Getting in Trouble: You have the right to a paper copy of this notice. Please contact the SHBP HIPAA Privacy Unit or print it from www.dch.ga.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Addresses for Complaints:

SHBP HIPAA Privacy Unit P.O. Box 1990, Atlanta, Georgia 30301-1990
404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)

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

Section 13: Glossary of Defined Terms

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

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.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the SHBP and UnitedHealthcare. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the amount you must pay for Covered Health Services in a Plan year before the SHBP will begin paying for Benefits in that Plan year.

The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See the definition of Eligible Expenses below.

Autism Spectrum Disorders – a group of neurobiological disorders that includes *Autistic Disorder, Rbett’s Syndrome, Asperger’s Disorder, Childhood Disintegrated Disorder, and a Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan. UnitedHealthcare (also known as United HealthCare Services, Inc.) is the Plan's Claims Administrator.

Clinical Cancer Trial Services - clinical trials study the effectiveness of new interventions. There are different types of cancer clinical trials such as:

- prevention trials;
- early detection trials;
- treatment trials to test new therapies in individuals who have cancer;
- quality of life studies;
- studies to evaluate ways of modifying cancer-causing behaviors.

Clinical trials follow strict scientific guidelines that deal with many areas such as:

- study design,
- who can be in the study,
- the kind of information individuals in the study must be given when they decide to participate.

Clinical trials follow protocols for determining:

- the number of Members;
- what drugs Members will take;
- what medical tests they will have; and
- how often and what information will be collected.

There are four phases of clinical trials. Clinical trials pilot program will include all phases of clinical trials, as long as they meet the criteria defined for the program.

Phase I Trials evaluate how a new drug should be administered and enroll only a small number of patients.

Phase II Trials provide preliminary information about how well a new drug works and generates more information about safety and benefits of the new drug or procedure.

Phase III Trials compare a promising new drug, a combination of drugs or a procedure with the current standard. This phase involves large numbers of people in doctors' offices, clinics and cancer centers. (Many of our members will be in this category). This phase utilizes a randomized process of assigning Members to the standard intervention or the trial intervention.

Phase IV Trials continue the evaluation of drugs after FDA approval and utilize drugs already on the market and available for general use.

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

Coinsurance - the charge you are required to pay for certain Covered Health Services is a percentage of Eligible Expenses determined after applicable deductibles have been met.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment is a set dollar amount that you pay at the time services are rendered.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by UnitedHealthcare on behalf of SHBP.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions.

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 SPD are references to a Covered Person. Also referred to as "Member".

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - your eligible dependent(s) that participates in the Plan, which can include an eligible spouse, natural child, Step Child, Legal Child or totally disabled child.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with UnitedHealthcare or with an organization contracting on its behalf to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable, except urinary catheters, ostomy supplies and disposable items that are considered an integral part of covered DME.
- Is manufactured and used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged through UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated.

Eligible Person - The Member who may be the employee, teacher, retiree, contract employee or extended beneficiary who is eligible for Plan coverage and who has paid the necessary deduction or premium for such coverage.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- 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.

Enrolled Member - the contract holder who may be the employee, teacher, retiree, contract employee or extended beneficiary and who is currently enrolled in coverage and who has paid the necessary deduction or premium for such coverage.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made 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.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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, that is both of the following:

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

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the SHBP, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

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

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (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 Use Disorder 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.

Intermediate Care – Mental Health or Substance Use Disorder treatment that encompasses one the following:

- Care at a Partial Hospitalization/Day Treatment Program.
- Care through an Intensive Outpatient Treatment Program.

Medicare - Parts A, B 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.

Medicare Advantage Option – option offered to SHBP retirees who have a minimum of Medicare Part B.

Member -Refer to Enrolled Member.

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 Designee - the organization or individual, designated by UnitedHealthcare, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - 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 them 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 a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by the SHBP.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayment/Coinsurance you pay every Plan year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that Plan year.

Copayment/Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in Section 1: What's Covered--Benefits and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- Copayment/Coinsurance for Covered Health Services available by an optional Rider.
- Any Copayment/Coinsurance for Covered Health Services in Section 1: What's Covered--Benefits that do not apply to the Out-of-Pocket Maximum.

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.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

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. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - Choice Plan for Georgia Department of Community Health State Health Benefit Plan.

Plan Administrator - Georgia Department of Community Health.

Plan Sponsor - Georgia Department of Community Health.

Preventive/Routine Care - is a set of measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages (for men age 45 to 79 years and for women age 55 to 79 years)*
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults beginning at 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
- **Obesity** screening and counseling for all adults

- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women 40 and older
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** interventions to support and promote breast feeding
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Folic Acid** supplements (containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid) for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Osteoporosis** screening at age 60 for women at increased risk
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk

- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for preschool children older than 6 months of age without fluoride in their water source*.
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b

- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

* Must obtain a prescription from your doctor and meet the age/gender requirements.

Qualified Medical Child Support Order (QMCSO) – Any judgment, decree, order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues. The order must provide for medical coverage for your natural child.

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.

Retiree Option Change Period - a period of time that follows the Initial Enrollment Period during which Eligible Retiree may elect to change their coverage option.

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.

SHBP – State Health Benefit Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spinal Treatment Provider - licensed Chiropractor.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse 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 a non-contracted physician at the benefit level associated with contracted 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.

- 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.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (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.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and UnitedHealthcare may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and UnitedHealthcare must determine that the procedure or treatment is

promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Choice Plan

Outpatient Prescription Drug Rider

Outpatient Prescription Drug Rider

This Rider to the Summary Plan Description provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of 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 13: Glossary of Defined Terms of the Summary Plan Description and in Section 3: Glossary of Defined Terms of this Rider. When we use the words "we," "us," and "our" in this document, we are referring to Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description Section 13: Glossary of Defined Terms.

Note: The Coordination of Benefits provision Section 7: Coordination of Benefits in the Summary Plan Description does apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described under “Coordination of Benefits (COB)” section, page 145.

Introduction

Benefits for Outpatient Prescription Drug Products

UnitedHealthcare administers your pharmacy benefit program. UnitedHealthcare uses Medco Health Solutions, Inc. (Medco) for certain pharmacy administrative services such as claims processing and customer care.

This rider will cover a detailed description about your prescription drug plan, including: prescription drug list; supply limits; notification (prior authorizations); maintenance medications; covered medications; non-covered medications; definitions of brand name medications and generic medications; and the Progression Rx program.

Benefits are available for outpatient Prescription Drug Products on the Prescription Drug List (which meet the definition of a Covered Health Service) at a Network Pharmacy is subject to Copayment or other payments that vary depending on which of the three tiers of the Prescription Drug List the outpatient Prescription Drug are listed.

Note: For the most up to date coverage information (including supply limits, specific notification requirements, etc.) for Prescription Drug Products that meet the definition of a Covered Health Service, you may call the customer care number on the back of your ID card.

Coverage Policies and Guidelines

Your UnitedHealthcare pharmacy benefit provides coverage for a comprehensive selection of prescription medications governed by a Prescription Drug List (PDL). Covered Outpatient Prescription Drug Products are FDA-approved Prescription Drug Products

A PDL is a list that places commonly prescribed medications for certain conditions into tiers.

Prescription medications are categorized within three tiers. Each tier is assigned a copayment, the amount you pay when you fill a prescription, which is determined by your health plan.

Several factors are considered when deciding the placement of a medication on the UHC 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:

Our National Pharmacy and Therapeutics (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 efficacy of the medication.

The UnitedHealthcare PDL Management Committee 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, our PDL Management Committee makes a tier placement decision based on the overall value of the medication.

The PDL Management Committee helps to ensure access to a wide range of affordable medications for you.

UnitedHealthcare may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per Plan year. These changes may occur without prior notice to you.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Preventive Care Over-the-Counter (OTC) medications are covered as described in Preventive/ Routine Care definition in Glossary of Terms. In order for these drugs to be covered, you must obtain a prescription from your doctor and meet the age/gender requirements.

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 more or less for that Prescription Drug Product. Please consult the Prescription Drug List or access through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com, or call the Customer Care number on your ID card for the most up-to-date tier status.

Tier status and Copayments will not be overridden or changed on an individual basis.

Identification Card (ID Card) - Network Pharmacy

In order to utilize your prescription drug benefit at a Network Pharmacy, you must show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy. If you forget your ID card, you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the Pharmacy.

You may seek reimbursement from us as described in Summary Plan Description Section 6: How to File a Claim. 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 Network Pharmacy's contracted Prescription Drug Cost, less the required Copayment and an Ancillary Charge if applicable.

Designated Pharmacies (including Specialty Designated Pharmacy Network)

If you require certain Prescription drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

Effective August 1, 2011, for Specialty Prescription Drug Products, you are required to use a Designated Pharmacy. Specialty Prescription Drug Products obtained from a Non-Network Pharmacy are not eligible for coverage and you will be required to pay the Full Retail Cost for that Prescription Drug Product.

Please see the Prescription Drug Rider Glossary for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the heading *What's Covered—Prescription Drug Benefits* within the Prescription Drug Rider for details on Specialty Prescription Drug supply limits.

Limitation on Selection of Pharmacies

If we determine 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, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card.

Member Rights and Responsibilities

As a member, you have the right to express concerns about your State Health Benefit Plan 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.

Pharmacy Questions: 1-877-246-4189

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

State of Georgia - State Health Benefit Plan Members

6220 Old Dobbin Lane, FL 2

Columbia, MD 21045

Attn: GDCH-SHBP

UnitedHealthcare Disclaimer

This Summary Plan Description (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 State Health Benefit Plan. This Summary Plan Description (SPD) is not a contract and the benefits that are described can be terminated or amended by the State Health Benefit Plan according to applicable laws, rules, and regulations. Should any conflicts arise between this booklet and your official plan documents, the official plan documents will govern.

Section 1: What's Covered-- Prescription Drug Benefits

We provide 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.
- Refer to exclusions in your Summary Plan Description Section 2: What's Not Covered--Exclusions and as listed in Section 2 of this Rider.

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 retail, mail, or specialty network pharmacies.

You can obtain information about Network Pharmacies by calling the toll-free number on the back of your ID card or by logging onto www.myuhc.com.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned unless you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent). 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 Copayment in addition to the Ancillary Charges.

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.

Note: Some products are subject to additional supply limits based on criteria that UnitedHealthcare 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.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card.

Notification (also known as Prior Authorization or Coverage Review) Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist, or you are required to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare is to determine whether the Prescription Drug Product, in accordance with our approved guidelines:

- Meets the definition of a Covered Health Service and
- it is not Experimental, Investigational, or Unproven Service.

UnitedHealthcare may also require you to notify them or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing Provider, the pharmacist, or you are responsible for notifying UnitedHealthcare. When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare as required.

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 or through the Internet at www.welcometouhc.com/shbp or by logging onto www.myuhc.com or by calling Customer Care at the number on your ID card. If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, 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 UnitedHealthcare is notified within the plan year after you pay the full retail cost and the Notification is approved, you may request reimbursement from us as described in the Summary Plan Description Section 6: How to File a Claim.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from Medco by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or by logging onto www.myuhc.com. The Medco claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the Medco claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription or an explanation of benefits from your primary carrier (if applicable).

Please note: Notification approval will be required before the claim will be considered for reimbursement. If UnitedHealthcare is notified within the plan year after you pay the full retail cost and the Notification is denied, you will not be reimbursed.

Non-Participating Pharmacy Notification or If You Do Not Present Your ID Card

When Prescription Drug Products are dispensed at a non-participating or non-network pharmacy or if you do not present your ID card, Notification approval will be required within the plan year before the claim will be considered for reimbursement.

If UnitedHealthcare is notified after you pay Full Retail Cost (Usual and Customary Charge) and the notification is approved within the plan year you may request reimbursement from us as described in the Summary Plan Description Section 6: How to File a Claim.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from Medco by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or by logging onto www.myuhc.com. The Medco claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the Medco claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription.

When you submit a claim on this basis, you may pay more because you did not notify Care Coordination before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge that applies.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed and it is determined that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

Please note: Notification approval will be required before the claim will be considered for reimbursement. If UnitedHealthcare is notified within the plan year after you pay the full retail cost and the Notification is denied, you will not be reimbursed.

Progression Rx 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 ProgressionRx program requirements (also known as step therapy requirements). 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 ProgressionRx requirements through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card.

Clinical Appeal Process

If a notification, quantity limitation, and/or Progression Rx request is denied by Medco, you or your physician may initiate the clinical appeals process.

Please be informed that we recommend a physician initiate an appeal for a denied Notification decision by UnitedHealthcare so that all necessary clinical information can be obtained.

The physician's request/appeal must be submitted in writing (via letter) to us for consideration. A physician must submit an appeal 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:

State of Georgia - State Health Benefit Plan Members
6200 Old Dobbin Lane, FL 2
Columbia, MD 21045

Attn: GDCH-SHBP

UnitedHealthcare will advise the physician and the member, in writing, of its decision. If UnitedHealthcare upholds the denial, information regarding the second-level appeal process will be provided to the physician and the member.

Second-level appeals (an appeal to the first-level appeal decision described above) must be initiated by a physician and, must be received in writing (via letter). The second level appeal must be

submitted within 60 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 should be forwarded to UnitedHealthcare to the address above. **The second level appeal decision is the final decision.**

If, after exhausting the two levels of appeal, 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 or Investigational Services 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 UnitedHealthcare at the toll-free number on your ID card for more information.

How to Fill Your Prescription at a Non-Participating Pharmacy or at a Participating Pharmacy When You Do Not Present Your ID Card

When you use a non-participating pharmacy or if you do not show your ID card or provide verifiable information at a participating pharmacy, you must pay the full retail cost (Usual and Customary Charge) for your prescription and then submit a claim form to Medco for reimbursement of covered drug costs. Assignment of Benefits (AOB) is not available except for military facilities such as Veterans' Administration hospitals, army bases, etc.

If you wish to seek reimbursement, you may obtain a claim form from Medco by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com. The Medco claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the Medco claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription or an explanation of benefits from your primary carrier (if applicable).

The prescription drug claim form must be filled out in its entirety. 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, the patient's name, and the patient's date of birth. A pharmacy receipt or an explanation of benefits from your primary carrier (if applicable) is also required with the claim form.

You may request reimbursement from us as described in the Summary Plan Description Section 6: How to File a Claim. You must submit your pharmacy receipt and claim form to the address identified on the claim form. You will be reimbursed the Prescription Drug Cost less the applicable Copayment and any Ancillary Charges if applicable. Also, you are subject to benefit plan rules (including but not limited to Notification and Progression Rx) as well as balance billing if the charged amount exceeds the network cost of your prescription(s).

Coordination of Benefits (COB)

If your spouse or a dependent has primary coverage from another health plan or Medicare Part D, prescription drug benefits provided by the State Health Benefit Plan (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 Medco at the time of purchase you can request the Pharmacist to electronically file SHBP secondary. By mail you can send a Medco prescription claim form and attach a copy of the Explanation of Benefits (EOB) form from the primary plan or the pharmacy receipt. You can obtain a copy of the Medco claim form by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com.

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, less any applicable copayments. **Note:** The amount paid will not exceed the allowable amount payable by the SHBP, less any applicable copayments.

Please contact Medco at the Customer Care number on your ID card for more details.

If you have coverage under two State Health Benefit Plan contracts (cross-coverage) prescription drug benefits provided by the State Health Benefit Plan will not be coordinated. A copayment will be required for each filled prescription. . If you have coverage under a Medicare Advantage plan benefits provided by the State Health Benefit Plan pharmacy benefits will not be coordinated.

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table, in addition to any Ancillary Charge when Prescription Drug Products are obtained from a Network or Non-Network retail pharmacy or Network mail order pharmacy or specialty Designated Pharmacy.

The Ancillary Charge applies when you request the Pharmacist to dispense a brand name drug when a generic equivalent at a lower copayment level exists.

The amount you pay for any of the following under this Rider will not be included in calculating **any Out-of-Pocket Maximum stated in your Summary Plan Description:**

- Copayment for Prescription Drug Products
- Ancillary Charges for Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Prescription Drug Cost (our contracted rates) will not be available to you.

Payment Information

Payment Term	Description	Amounts
Copayment	<p>Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.</p> <p>Your Copayment is determined by the State Health Benefit Plan and tier status is determined by UnitedHealthcare's Prescription Drug List Management Committee has assigned a Prescription Drug Product.</p> <p>Note: The tier status of a Prescription Drug Product can change periodically, generally twice a year but no more than six times per Plan year, based on UnitedHealthcare's Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myuhc.com through the Internet, or call the Customer Care number on your ID card for the most up-to-date tier status.</p> <p>Tier Status and Copayments will not be overridden or changed on an individual basis.</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Copayment or • The applicable Copayment and Ancillary Charge or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and if applicable sales tax) for that Prescription Drug Product. <p>For Prescription Drug Products at a mail service Network Pharmacy or a specialty Designated Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Copayment or • The applicable Copayment and Ancillary Charge or • The Prescription Drug Cost for that Prescription Drug Product. <p><i>See the Copayment stated in the Benefit Information table for amounts.</i></p>

Benefit Information

Description of Pharmacy Type and Supply Limits

Your Copayment Amount

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a 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-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.

(Please note: For covered prescription drug products dispensed from a Non-network pharmacy or dispensed from a Network pharmacy without your ID card 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 Copayment in addition to Ancillary Charges.
- * **Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.**

Your Copayment is determined by the tier to which UnitedHealthcare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.

Coverage up to 31-day supply:

\$20 per Prescription for a **Tier-1 Prescription Drug Product.**

\$50 per Prescription for a **Tier-2 Prescription Drug Product.**

\$90 per Prescription for a **Tier-3 Prescription Drug Product.**

* If the Usual or Customary price is less than the Copayment, you will pay the lesser amount.

Specialty Prescription Drug Products from a Designated Pharmacy

For Benefits provided for outpatient Specialty Prescription Drug Products dispensed by a Specialty Designated Pharmacy, the following apply:

- As written by a Physician.
- 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 a specialty Designated Pharmacy to receive in-network coverage for specialty prescription medications covered under the pharmacy benefit. If you do not use a specialty designated pharmacy, the specialty prescription is not eligible for coverage and you will be required to pay the full retail cost for that prescription at the pharmacy.

Initially, you may obtain the first two (2) fills of your specialty Prescription Drug Product from a participating retail pharmacy. Thereafter, you will be required to use a participating specialty Designated Pharmacy to continue coverage for your specialty Prescription Drug Product. You will pay the in-network Copayment.

Please note if you use a non-specialty Designated Pharmacy, your specialty prescription is not eligible for coverage and you will be required to pay the full retail cost for that prescription at the pharmacy.

Specialty medications are not a part of the home delivery (mail order) benefit. After the first fills, in order to continue to receive in-network benefits, you must use a specialty Designated Pharmacy. You can continue to fill your non-specialty prescriptions at a regular participating retail or mail order pharmacy.

Your Copayment is determined by the tier to which UnitedHealthcare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.

Coverage up to 31-day supply:

\$20 per Prescription for a **Tier-1 Prescription Drug Product.**

\$50 per Prescription for a **Tier-2 Prescription Drug Product.**

\$90 per Prescription for a **Tier-3 Prescription Drug Product.**

*** If the Usual or Customary price is less than the Copayment, you will pay the lesser amount.**

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 Copayment in addition to Ancillary Charges.

Maintenance Prescription Drugs from a Retail Network Pharmacy

Maintenance Prescription Drug products are medications taken on an ongoing basis for the treatment of chronic conditions such as diabetes, ulcers or high blood pressure. 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 2 tablets a day, your physician must write a prescription for a quantity of 180 tablets to be dispensed).

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;
- Medications for the treatment of multiple sclerosis
- Oral Contraceptives and;
- Thyroid medications.

You will be charged one copayment per 31-day supply. Please call the Customer Care number if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

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 Copayment in addition to Ancillary Charges.

Your Copayment is determined by the tier to which UnitedHealthcare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.

Coverage up to 90-day supply:

\$60 per Prescription for a **Tier-1 Prescription Drug Product.**

\$150 per Prescription for a **Tier-2 Prescription Drug Product.**

\$270 per Prescription for a **Tier-3 Prescription Drug Product.**

*** If the Usual or Customary price or the Network Pharmacy discounted price is less than the Copayment, you will pay the lesser amount.**

Prescription Drug Products from a Home Delivery Network Pharmacy

Benefits for outpatient Prescription Drug Products dispensed by a mail service Network Pharmacy. The following supply limits apply:

- 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). **Please note you will be charged a mail-order Copayment regardless of the days supply written on the prescription.**

To obtain your prescription from a mail order pharmacy, simply follow the instructions below and pay the Copayment, after meeting the Annual Deductible.

1. Call the toll free phone number on the back of your ID Card or
2. Log onto www.myuhc.com

To receive the maximum Benefit, you should ask your provider to write your Prescription Order or Refill for the full 90 days.

When you obtain a maintenance supply of drugs from a Home Delivery Network Pharmacy, your cost sharing may be lower. UnitedHealthcare offers two ways to obtain up to a 90 day supply of maintenance drugs.

1. Some retail pharmacies in our network allow you to get maintenance drugs up to a 90 day supply. Some of these retail pharmacies may agree to accept the mail order cost sharing amount for maintenance drugs. Other retail pharmacies may not agree to accept the mail order cost sharing amount for

Your Copayment is determined by the tier to which UnitedHealthcare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.

Coverage up to a consecutive 90-day supply:

\$50 per Prescription for a **Tier-1 Prescription Drug Product.**

\$125 per Prescription for a **Tier-2 Prescription Drug Product.**

\$225 per Prescription for a **Tier-3 Prescription Drug Product.**

**Description of
Pharmacy Type and Supply Limits**

Your Copayment Amount

maintenance drugs. Your pharmacy directory lists which pharmacies can give you a maintenance drug for your mail order benefit.

Your pharmacy directory is located at www.welcometouhc.com/shbp

2. You can use the UnitedHealthCare's Network mail order services (the Medco Pharmacy).

Home Delivery from a Non-Network Pharmacy is NOT covered.

Section 2: What's Not Covered-- Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in 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.
5. 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 UnitedHealthcare to be experimental, investigational or unproven.
6. 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.
7. 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.
8. Any product dispensed for the purpose of appetite suppression and other weight loss products.
9. An injectable medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by UnitedHealthcare, 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 Gardasil and Zostavax vaccines and self-administered injectable medications covered through your pharmacy benefit plan.
10. The cost of labor and/ additional charges for compounding prescriptions excluding contractual dispensing fees that pharmacies charge.
11. Charges for the administration or injection of any Prescription Drug Product.
12. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
13. General vitamins, except the following which require a prescription: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

14. Medications used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility.
18. Prescription Drug Products for smoking cessation.
19. Prescription and over-the-counter contraceptive jellies, creams, foams, devices and implants.
20. Yohimbine.
21. Mifeprex.
22. Blood or blood plasma product.
23. Compounded drugs that do not contain at least one ingredient that requires a prescription. (Compounded drugs that contain at least one ingredient that requires a prescription will be assigned to Tier-3.)
24. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed (except for the certain preventive OTC drugs – Aspirin, Fluoride, Folic acid and Iron which require a prescription for coverage). Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
25. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by UnitedHealthcare's Prescription Drug List Management Committee.
26. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.

Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in Section 13: Glossary of Defined Terms of your Summary Plan Description.
- Is not intended to describe Benefits.

Ancillary Charge - a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the brand name Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the chemically equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all

products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with UnitedHealthcare 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. (Effective August 1, 2011, includes Specialty 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: (1) that is chemically equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand 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 UnitedHealthcare.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare 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 UnitedHealthcare as a Network Pharmacy.

A Network Pharmacy can be either a retail or specialty Designated Pharmacy or a mail service 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 UnitedHealthcare's Prescription Drug List Management Committee.
- December 31st of the following Plan year.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Care number on your ID card.

Prescription Drug List Management Committee – the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration 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. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices;
 - Glucose monitors.

Effective August 1, 2011: Specialty Prescription Drug – Prescription Drug Product that is generally high cost, self-injectable biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Infertility. You may access a complete list of Specialty Prescription Drugs through the Internet at www.myuhc.com or by calling the number on the back of your ID card.

Usual and Customary Charge - The amount that a pharmacist would charge a cash-paying customer for a prescription.

Section 4: Frequently Asked Questions

This section:

- Help you understand your medication choices and make informed decisions.
- Help you understand which questions to ask your doctor or pharmacist.

What is a Prescription Drug List (PDL)?

A PDL is a list of Food and Drug Administration (FDA) approved brand name and generic medications.

The UHC Prescription Drug List (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 our various committees. The list is updated to reflect decisions based on new medical evidence and information. Additionally, the United States Food and Drug Administration (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 UnitedHealthcare pharmacy benefit provides coverage for a comprehensive selection of prescription medications. You can check which medications are on which tiers at www.myuhc.com. You and your doctor may 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. Each tier is assigned a copayment, the amount you pay when you fill a prescription, which is determined by your health 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 2 Your Midrange-Cost Option	Tier 3 Your Highest-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.	This is your middle copayment option. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is right for your treatment.	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 one or more ingredients that are prepared “on-site” by a pharmacist. These are classified at the Tier 3 level.

What factors are looked at for 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 UHC 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:

Our National Pharmacy and Therapeutics (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 efficacy of the medication.

The UnitedHealthcare PDL Management Committee 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, our PDL Management Committee makes a tier placement decision based on the overall value of the medication.

The PDL Management 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. 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. These changes may occur without prior notice to you. For the most current information on your pharmacy coverage, please call our Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com.

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 cost option. **Note:** Some generic medications may be in Tier 2 or Tier 3 and will not have the lowest copayment available under your pharmacy benefit plan. Go to www.myuhc.com to determine the copayment for your generic medication.

Why is a generic drug in Tier 2 or Tier 3?

Our PDL is not structured like the traditional PDLs where all generics are placed in Tier 1 regardless of their costs. Our PDL looks at the overall value of the generic or brand name drug. Although generic drugs are usually your lowest-cost option, they are not always less expensive than brands. High-cost generics may be placed in a higher tier, Tier 2 or Tier 3 and will not be the lowest cost option available under your pharmacy benefit plan. In addition, for some medications the brand name may be in a lower tier, Tier 2 or Tier 1, than its generic equivalent. Please call the toll-free Customer Care phone number on the back of your health plan ID card or visit www.welcometouhc.com/shbp or log on myuhc.com for more information about generic medications.

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 medication. For possible coverage alternative, please call the Customer Care number on your ID card.

When should I consider discussing over-the-counter or non-prescription medications with my doctor?

An over-the-counter medication can be an appropriate treatment for many conditions. Consult your doctor about over-the-counter alternatives to treat your condition. These medications are not covered under your pharmacy benefit, 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 medications taken on an ongoing basis for the treatment of chronic conditions such as diabetes, ulcers or high blood pressure. Maintenance medications are those prescribed medications that a member may obtain for a period of up to 90 days.

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 2 tablets a day, your physician must write a prescription for a quantity of 180 tablets to be dispensed). You will be charged one copayment per 31-day supply.

Please call the Customer Care number if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

Certain medications have been categorized as maintenance medications.

What 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;
- Medications for the treatment of multiple sclerosis;
- Oral Contraceptives and;
- Thyroid medications.

Please call your Customer Care number on your ID card if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

What are the Supply Limits (SL) programs?

The Supply Limits (SL) program defines the maximum quantity that can be dispensed per copayment (Quantity Level Limit or QLL) or specified timeframe (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 Supply Limit (SL) programs work?

If your prescription exceeds the supply limit, your pharmacist will be notified of the quantity covered for one copayment. You will have the following options:

- Accept the established quantity limit;
- Pay additional out-of-pocket costs or copayments for amounts that exceed the quantity limits (as appropriate);
- Discuss alternatives with your doctor before deciding whether to fill the prescription; and
- Request coverage authorization for the additional amounts through the coverage review process (when available).

What is the Notification program?

Notification (also known as prior authorization or coverage review) is a set of clinical rules designed to support the pharmacy benefit at the time the prescription is dispensed. It is applied to a very 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 Notification 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 UnitedHealthcare with information to determine if the prescription meets the coverage conditions of your pharmacy benefit. We will review the information and approve or deny coverage. We 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 our Customer Care number on your ID card to determine whether or not 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?

Each plan year (calendar year), you are allowed to obtain up to a 6 months supply for each prescription.

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 Medco pharmacy helpdesk at (800) 922-1557.

You may also locate a network pharmacy at your vacation destination by calling our Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com.

How do I access updated information about my pharmacy benefit?

Since the PDL may change periodically, we encourage you to log on www.myuhc.com or visit www.welcometouhc.com/shbp or please call our Customer Care number on your ID card for more current information.

Log on to www.myuhc.com 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 our Customer Care number on your ID card.

Representatives are available to assist you 24 hours a day, except Thanksgiving and Christmas.

- End of Outpatient Prescription Drug Rider -

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayment and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Patient Protection and Affordable Care Act (“PPACA”)

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the toll-free number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) 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, contact the Claims Administrator at the toll-free number on the back of your ID card.

