Summary Plan Description

United HealthCare Choice Plan

for

Georgia Department of Community Health

Group Number: 702030
Effective Date: July 1, 2005

Table of Contents

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

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 limitation 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 9: General Legal Provisions* to better understand how this SPD and your Benefits work. You should call the United HealthCare 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.

To continue reading, go to right column on this page.

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 10: Glossary of Defined Terms*. You can refer to Section 10 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 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 10: Glossary of Defined Terms*.

Customer Service and Claims Submittal

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

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Prior Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: 1-866-527-9599

To continue reading, go to left column on next page.

Claims Submittal Address:

United HealthCare Insurance Company

PO Box 740800

Atlanta, Georgia 30374-0800

866-527-9599

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 740800

Atlanta, Georgia 30374-0800

866-527-9599

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments 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 United HealthCare before you receive them. In general, Network providers are responsible for United HealthCare before they provide certain health services to you.

Accessing Benefits

You must see a Network Physician to obtain Benefits. For details, see *Section 3: Obtaining Benefits*.

You must show your identification card (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.

To continue reading, go to right column on this page.

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 8: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see *Section 10: Glossary of Defined Terms*. Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses are the amount that we will pay for Benefits, as determined by us or by our designee. In almost all cases our designee is United HealthCare. For a complete definition of Eligible Expenses that describes how payment is determined, see *Section 10: Glossary of Defined Terms*.

We have delegated to United HealthCare 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.

To continue reading, go to left column on next page.

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 United HealthCare before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying United HealthCare.

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify United HealthCare before receiving Covered Health Services.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	$100 per Covered Person per calendar year, not to exceed $200 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Coinsurance. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	$500 per Covered Person per calendar year, not to exceed $1,000 for all Covered Persons in a family. The Annual Deductible is included in the Out-of-Pocket Maximum.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under and of The State Health Benefit Plans (SHBP). For a complete definition of Maximum Plan Benefit, see *Section 10: Glossary of Defined Terms*.	$2,000,000 per Covered Person per lifetime (combined for all SHBP options)

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Services considered non-emergency when part of a monitored or authorized care plan.	*Ground Transportation:* 0% *Air Transportation:* 0%	No	No
2. Dental Services Dental services when all of the following are true: • 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. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin 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	Oral Surgery in an office: $25 In and out patient facility charges: 0%	No No	No Yes

therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident.
- Completed within 12 months of the accident.

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

Notify United HealthCare

Please notify United HealthCare at the telephone number on your ID card 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.).

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Durable Medical Equipment (including foot orthotics) Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. 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 standard wheelchair. • 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).	0%	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part 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, except foot orthotics, 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). We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every Plan Year. United HealthCare will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor United HealthCare identifies.			
4. Emergency Health Services 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. You will find more information about Benefits for Emergency Health Services in *Section 3: Obtaining Benefits*.	$100 per visit	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Eye Examinations Eye examinations received from a health care provider in the provider's office. Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider every other Plan Year. Expenses for glasses and contacts are covered regardless of provider status. If hardware is purchased from a participating provider the member does not need to pay in full and submit a claim form. **The participating provider will fill a claim and the provider will be reimbursed the negotiated rate up to $200.00.** If a non par provider is used the member must pay for expenses and file receipt with claim form for reimbursement. Benefits are limited to one visit every 24 months. Please use a vision claim form found on the Georgia Department Community Health website, www.provider.uhc.com/gdch or call customer service.	$25 per visit. **$200 maximum per Plan Year for combination of glasses and/or contacts.**	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • 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. • 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.	0%	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
United HealthCare 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. Benefits are limited to 60 visits per Plan Year.			
7. Hospice Care 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 United HealthCare for more information regarding guidelines for hospice care. You can contact United HealthCare 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 policy year.	0%	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	10%	Yes	Yes
9. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	Injections & Allergy Shots: $25 per visit. No Copayment applies when a Physician charge is not assessed.	No	No
10. Infertility Services Benefits are available for the underlying medical condition of infertility only. *Please also refer to *Section 2: What's Not Covered--Exclusions* under item *L. Reproduction*.	10%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		
There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify United HealthCare during the first trimester, but no later than one month prior to the anticipated childbirth.	No Copayment applies to Physician office visits for prenatal care after the first $25 visit.		
We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Mental Health and Substance Abuse Services - Outpatient **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment United Behavioral Health (UBH). The UBH phone number that appears on your ID card is 1-866-527-9599. Please contact UBH prior to receiving services to verify you are using a UBH provider – no benefits will be paid if a UBH provider is not used. Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management.	$25 per individual visit $10 per group visit.	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 13 visits per Plan Year.			
13. Mental Health and Substance Abuse Services - Inpatient and Intermediate **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment UBH. The UBH phone number that appears on your ID card is 1-866-527-9599. Without authorization, you will be responsible for paying all charges and no Benefits will be paid. Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care, care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but greater than the level of room and board, basis in a Hospital or an Alternate Facility. Benefits include	10%	Yes	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. UBH, who will arrange for the services and will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the UBH, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Mental Health Services and Substance Abuse Services must be provided by or under the direction UBH. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of UBH, who is responsible for coordinating all of your care. Contact UBH regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 15 days per Plan Year.			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Ostomy Supplies	0%	N/A	No
15. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Surgery and related services. • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits under this section include only the facility charge and 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* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	10%	Yes	Yes
Mammography testing:			
Routine: 0%	No	No	
Non-routine: 10%	Yes	Yes	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Well-baby and well-child care. • Routine physical examinations. • Immunizations. (no copayment for routine services). • Treatment of a Sickness or Injury. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.)	$20 per visit for PCP. $25 per visit for specialist. No Copayment applies when no Physician charge is assessed.	No	No
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. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	10%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every Plan Year.	0%	No	No
19. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. 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.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. 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. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast cancer, 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 United HealthCare at the telephone number on your ID card for more information about Benefits for mastectomy related services.			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. (20 visits) • Occupational therapy. (20 visits) • Speech therapy. (20 visits) • Pulmonary rehabilitation therapy. (20 visits) • Cardiac rehabilitation therapy. (20 visits) 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. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.	$25 per visit		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Please note that 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. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services are limited to 60 days per Plan Year.	10%	Yes	Yes
22. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment when provided by a Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits for Spinal Treatment are limited to 10 visits per Plan Year.	$25 per visit	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
23. Temporomandibular Joint Syndrome Services (TMJ) Covered Health Services for TMJ for all diagnostic and non-surgical and surgical treatment under normal application of plan benefits excluding appliances and orthodontic care.	$25 per visit	No	No
24. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician. Transplantation services must be received at a United Resource Network Designated Facility. 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: • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants.	10%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact United HealthCare at the telephone number on your ID card for information about these guidelines.			
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 *Physician's Office Services* earlier in this section.	$25 per visit		
246. Wisdom Teeth (Impacted Only) Impacted wisdom teeth are covered under the medical plan. If wisdom teeth are not impacted this will be covered under the dental plan.	$25 per visit	No	No

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. It's important for you to know what services and supplies are not covered under the Plan.

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.

To continue reading, go to right column on this page.

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. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

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 and speech.

To continue reading, go to left column on next page.

C. Dental

1. Dental care except as described in *Section 1: What's Covered--Benefits* under the heading *Dental Services - Accident Only* and under the heading *Wisdom Teeth (Impacted Only).*
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
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.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
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.

To continue reading, go to right column on this page.

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).
2 Nail trimming, cutting, or debriding.
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.
5. Treatment of subluxation of the foot.
6. Shoe orthotics.

To continue reading, go to left column on next page.

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. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Syringes.
   - Diabetic test strips.
3. Orthotic appliances that straighten or re-shape a body part (including some types of braces).
4. Tubings, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

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. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Treatment for insomnia and other sleep disorders, dementia, 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 the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

To continue reading, go to right column on this page.

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The Mental Health/Substance Abuse 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.

I. Nutrition

1. Megavitamin and nutrition-based therapy.
2. Nutritional counseling for either individuals or groups, with exception for diabetic counseling as approved by Care Coordination[SM].
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 10: 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.

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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, with exception of hair loss relating to chemotherapy treatment.

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. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Drug Therapy.
5. In-Vitro fertilization.

To continue reading, go to left column on next page.

6. Gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures.

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 for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.

To continue reading, go to right column on this page.

5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in *Section 1: What's Covered--Benefits*.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Exception travel expenses is for related to covered transplantation services.

P. Vision and Hearing

1. 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.
2. Hearing aids or costs associated with hearing aids.
3. Fitting charges for hearing aids, eyeglasses and contact lenses.
4. Eye exercise therapy.

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 10: 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.

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- 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. Surgical and non-surgical treatment of obesity, including morbid obesity.
8. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, except as a treatment of obstructive sleep apnea.
9. Growth-hormone therapy, with the exception of diagnostic testing to rule out a diagnosis. Once diagnosed growth-hormone therapy is not covered.
10. Sex transformation operations.
11. Custodial Care.
12. Domiciliary care.
13. Private-duty nursing.
14. Respite care.
15. Rest cures.
16. Psychosurgery.

To continue reading, go to right column on this page.

17. Treatment of benign gynecomastia (abnormal breast enlargement in males).
18. Medical and surgical treatment of excessive sweating (hyperhidrosis).
19. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
20. Oral appliances for snoring.
21. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
22. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
23. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
24. Any charge for services, supplies or equipment advertised by the provider as free.
25. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
26. Any charges prohibited by federal anti-kickback or self-referral statutes.
27. Any additional charges submitted after payment has been made and your account balance is zero.
28. Any outpatient facility charge in excess of payable amounts under Medicare.
29. Any charges by a resident in a teaching hospital where a faculty Physician did not supervise services.
30. Growth Hormone. (Diagnostic testing to rule out a diagnosis is covered, but once diagnosed growth hormones are not covered).

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Section 3: Obtaining Benefits

This section includes information about:
- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services that 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.

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

Please note that Mental Health and Substance Abuse Services must be authorized by United Behavioral Health (UBH). Please see *Section 1: What's Covered--Benefits* under the heading for *Mental Health and Substance Abuse*.

To continue reading, go to right column on this page.

Provider Network

United HealthCare arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of United HealthCare. 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.

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling United HealthCare.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider.

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 or contact United HealthCare for assistance.

To continue reading, go to left column on next page.

Care Coordination[SM]

Your Network Physician is required to notify United HealthCare regarding certain proposed or scheduled health services. When your Network Physician notifies United HealthCare, they will work together to implement the Care Coordination[SM] 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 United HealthCare. The Covered Health Services for which notification is required is shown *in Section 1: What's Covered--Benefits*. When you notify United HealthCare, you will be provided with the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that United HealthCare 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, United HealthCare 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 United HealthCare.

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 United HealthCare, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

To continue reading, go to right column on this page.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Limitations on Selection of Providers

If United HealthCare 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, United HealthCare 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.

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, United HealthCare must be notified within one business day or on the same day of admission if reasonably possible. United HealthCare 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 United HealthCare

To continue reading, go to left column on next page.

decides a transfer is medically appropriate, Benefits will not be available.

- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Note: Please note that the Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the Emergency Copayment will apply instead of the Copayment for an Inpatient Stay.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

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.

Note: If any conflict exists between this summary plan description and the laws of the State of Georgia or with the polices of the State Health Benefit Plan (SHBP), the laws of the State of Georgia or the polices of SHBP will govern at all times.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. SHBP or its designee will give the necessary forms to you, along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

To continue reading, go to right column on this page.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits 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 United HealthCare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services from Network Providers.

To continue reading, go to left column on next page.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility

Eligible Person	You are eligible to enroll yourself and your eligible dependents for coverage if you are:
	• A Full-time employee of the State of Georgia, the General Assembly, or an agency, board, commission, department, county administration, or contraction employer that participates in SHBP, as long as:
	  • You work at least 30 hours a week consistently, and
	  • Your employment is expected to last at least nine months.
	  Not Eligible: Student employees or seasonal, part-time, or short-term employees.
	• A certified public school teacher or library employee who works half-time or more, but not less than 18 hours a week.
	  Not Eligible: Temporary or emergency employees.
	• 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.
	• An employee who is eligible to participate in the Public 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.
	• 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.
		We determine who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
	• An employee in other groups as defined by law.	
Dependent	Eligible dependents are: • Your legally married spouse • Your never-married dependent children who are: • Natural or legally adopted children under age 19, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody. • Stepchildren under age 19 who live with you at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents. • Other children under 19 if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction. • Your natural children, legally adopted children or stepchildren 19 or older from categories 1 and 2 above who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19. • Your natural children, legally adopted children, stepchildren or other children age 19 to 26 from categories 1, 2 and 3 above who are registered Full-time Students at fully accredited schools, colleges, universities, or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for Full-time Student status is defined by the school in which the child is enrolled.	We determine who qualifies as a Dependent.

When requested by the Plan, you will be required to provide documents such as a marriage license, birth certificate, adoption contract or judge-signed court order to verify your dependent relationship. The Plan has the right to determine whether or not the documentation satisfies Plan requirements. If verification cannot be made, the dependent's coverage will be terminated retroactively to his or her coverage effective date. The Plan will make every effort allowable under the law to recover any and all payments made by the Plan on behalf of an ineligible dependent.

Documentation Required For Eligible Covered Dependents Age 19 or Older

Coverage does not continue automatically at age 19. This chart describes what you must do to request continued coverage as your child nears age 19.

For a Covered Dependent age 19 & older…

- … and a Full-time Student under the age 26

You must:

- update SHBP annually on student status by requesting a *certification letter* from the school's registrar and sending it with a *Dependent Student Status Information Form* to SHBP
- file a written request for continuation of coverage prior to the 19th birthday or within 90 days after the 19th birthday and provide satisfactory documentation of disability
- the certification letter must include:
    - enrollment date(s) for both current and previous quarters or semesters

- number of credit-hours taken each quarter or semester
- enrollment status (full- or part-time) for each quarter of semester

For a Covered Dependent age 19 & older…

- … and disabled as a covered SHBP Member before age 19

You must:

- file a written request for continuation of coverage prior to the 19th birthday or within 90 days after the 19th birthday and provide satisfactory documentation of disability

If you have a disabled child who is already age 19 when you enroll, the child is not eligible for coverage. However, if you disabled child loses coverage under another plan, you can apply for SHBP coverage on the child if you *were eligible for SHBP coverage on your child's 19th birthday*. To apply, send the Plan a written request and documentation on your child's disability and loss of other coverage within 90 days of the dependent's loss of coverage. You must be a Member when application is made.

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 *to support your request* may be filed later, if not available when you submit your coverage request.

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.

Who's Not Eligible For Dependent Coverage

The most common examples of persons not eligible for SHBP dependent coverage include:

- Your former spouse
- Your fiancé
- Your parents
- Married or formerly married children
- Children age 19 or older who do not qualify as Full-time Students or disabled dependents
- Children 26 or older who are not already covered as a disabled dependent
- Children in military service
- Grandchildren who cannot be considered eligible dependents
- Stepchildren who do not live in your home at least 180 days per year.
- Anyone living in you home that is not related by marriage or birth, unless otherwise noted

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
- Select either single coverage or family coverage
- Name the eligible dependents you want to cover

Your signature on the enrollment form authorizes periodic payroll deductions for premiums. Your employer may also ask you to complete other forms. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualifying event under Section 125 of the Internal Revenue Code, which restricts mid-year changes in SHBP.

Special Note: If you terminate employment and are re-hired during the same Plan year, you must enroll in the same Plan option, provided you are eligible for that option.

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- Participant – You, the contract/policy holder
- Member – You and/or your eligible dependents that you choose to enroll

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

- Employee, retiree or Member… to refer to Participant
- Dependent(s)… to refer to Member

When You Can Enroll

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by SHBP, if SHBP receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	SHBP determines the Open Enrollment Period. Coverage begins on the date identified by SHBP if SHBP receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.

If you are:	You can enroll:	Your coverage takes effect:
▪ A current employee	▪ Or make coverage changes during Open Enrollment	▪ The upcoming July 1
	▪ Or make coverage changes within 31 days of a qualifying even; upon loss of all eligible dependents, within 90 days	▪ First of the month following request
▪ A newly hired employee	▪ Within 31 days of your date of hire	▪ First of the month after a full calendar month of employment

If You Have Coverage through a Different Health Plan

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date. You may not enroll until the next Open Enrollment period – unless you have a qualifying event.

Enrolling A Newly Eligible Dependent

This next chart describes what you need to do if you wish to add a newly eligible dependent.

	If you have to enroll a newly eligible dependent and…	You will need to:
Newly Eligible Dependent	… you already have family coverage	File a *Dependent/Miscellaneous Update Form* with SHBP … within 31 days of the birth, marriage or adoption placement
	… you do *not* have family coverage	Change your coverage type to family* by filing a *Membership Form* with your personnel/payroll office … within 31 days of the birth, marriage or adoption placement
	… you have a court order requiring you to enroll dependent child(ren)	Enroll the eligible child(ren); coverage starts on first day of month following the request. Change to family coverage if you have single coverage.

**To make coverage retroactive to the child's birth or placement, you must make family coverage premium payment(s) covering the month of the birth or adoption contract and placement.*

Identification Cards

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

If you do not receive your ID care within two weeks of enrollment, call your personnel/payroll office. Contact SHBP eligibility unit to replace lost or stolen ID cards.

When Coverage Begins

	If you enroll:	Your coverage begins:
For You When your coverage starts depends on when you enroll and when you make requests that affect your coverage.	During an Open Enrollment period	On July 1 of the new Plan Year
	As a new employee	On the first day of the month following one full calendar month of employment
	When you are reinstated or return to work from an unpaid leave of absence that occurred during the Open Enrollment period	On the first day of the month following the request or, if a judicial reinstatement, on the day specified in the settlement agreement

When to Enroll	Who Can Enroll	Begin Date
	When you have a qualifying event	On the first day of the month following the request

Transferring Employees

If you are transferring between participating employers:

- Contact your new employer to coordinate continuous coverage
- You must continue the same coverage, unless you had a qualifying even that made you ineligible to continue that coverage

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 Your Dependents

When you select family coverage as a new employee, dependent coverage begins when your coverage begins. If you add dependents later, coverage takes effect as described in the chart below:

If you add this dependent…	Coverage takes effect:
A baby	On the first day of the month following the request; On the day your child was born, if the family premium is paid from the birth month.* Copy of certified birth certificate required upon request
An adopted child	*When you already have family coverage.*

When to Enroll	Who Can Enroll	Begin Date
		On the date of legal placement and physical custody *When you change to family coverage within 31 days of the event:* On the date of legal placement and physical custody, if the family premium is paid from the time of placement and custody Copy of certified adoption certificate required upon request
	A new spouse	*When you already have family coverage:* On the day of your marriage *When you have single coverage:* On the first day of the month following the request Copy of certified marriage certificate required upon request **If necessary, you may change to family coverage before the birth to avoid retroactive premium payments.* You must enroll for dependent coverage and submit the required form(s) within 31 days of the birth, adoption, or marriage.

Qualifying Events that Allow Coverage Changes for Active Participants

If you are an actively employed Participant 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 event. If you are a retiree, refer to the retiree section for permitted coverage changes. The following chart shows qualifying events and the corresponding changes that active Participants can make.

If you have one of these events:	Within 31 days of event, you may:
Marriage	Enroll Change to family coverage Discontinue coverage; letter from other plan documenting your coverage is required Certified copy of marriage certificate required
Birth, adoption or legal guardian ship	Enroll Change to family coverage Certified copy of marriage certificate required
You lose coverage because of divorce	Enroll in United HealthCare option Change your coverage type Copy of divorce decree and loss-of-coverage documentation required

When to Enroll	Who Can Enroll	Begin Date
	You or your spouse loses coverage through other employment	Change to family coverage Letter from other employer documenting loss required
	You, your spouse, or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid or Medicare	Enroll in single or family coverage Change to any available option Letter from other employer, Medicaid, or Medicare documenting time and reason for loss of discontinuation required
	Your spouse or your only enrolled dependent's employment status changes, affecting coverage eligibility under a qualified plan	Change to single coverage Discontinue coverage Letter from other employer documenting affect on coverage eligibility required
	Your former spouse loses coverage or plan is cancelled, resulting in loss of your dependent child(ren) coverage	Enroll in any United HealthCare option Change to family coverage Letter from other plan documenting loss is required
	You acquire new coverage under spouse's employer's plan	Change to single coverage Discontinue coverage – you must document your spouse's coverage and current coverage for all dependents previously covered by your

When to Enroll	Who Can Enroll	Begin Date
		SHBP coverage Letter from other plan documenting your coverage is required
	Your spouse make an Open Enrollment change under spouse's employer's plan, creating an overlap or break in coverage has a different plan year	Enroll Change to single coverage Discontinue your coverage - you must document your spouse's coverage Letter from other plan documenting overlap or break in coverage is required
	You, your spouse, or enrolled dependent moves out of your HMO option's approved service area	Change to any available option Discontinue coverage – documentation of change in residence may be required
	Your HMO goes out of operation	Change to any available option – if you do not file your Membership Form within 31 days, you and any Covered dependent(s) will be enrolled automatically into the PPO Option
	You or your spouse is activated into military reservist services	Enroll in the United HealthCare option Change coverage type Copy of orders required

When to Enroll	Who Can Enroll	Begin Date
	You retire and immediately qualify for a retirement annuity	Change to United HealthCare option when you retire You must complete and submit Plan enrollment form no later than 60 days after leaving active employment
	You, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid	Discontinue your coverage Change to single coverage – if you are retired and you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage; Letter from Medicare or Medicaid documenting eligibility required Retirees may change to any available option upon becoming eligible for Medicare coverage.

If you lose all your Covered Dependents because of death, divorce, marriage of dependent, age, loss of full-time student status or other qualifying reason, you have *90 days from the date of the event* to complete the necessary form(s) to request a change from family to single coverage.

Qualified Medical Child Support Orders

You may make coverage changes during the Plan Year when you receive a Qualified Medical Child Support Order (QMCSO).

If a QMCSO requires:	You can file a Membership Form to:
You to provide coverage for your natural child(ren).	Enroll or change from single coverage to family coverage – there is no time limit for this change; documentation of the court order is required
Your former spouse to provide coverage for each of your enrolled natural child(ren)	Change from family to single coverage – within 90 days of the court-ordered date; documentation of the court order is required
	Generally, a change in coverage takes effect the first of the month following receipt of the change request.

Provisions for Eligible Retirees – and considerations for Participants near retirement

Plan Membership

This section includes Plan Membership and co-ordination of benefits information for eligible retirees as well as important points to consider if you are near retirement.

Eligibility

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
- Teachers Retirement System
- Public School Employees Retirement System
- 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 have withdrawn 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.

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,* avai9labe through your personnel/payroll office or by contacting the Plan's eligibility unit. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.**

When Coverage Begins

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

When Coverage Ends

For You

Coverage will end when you discontinue coverage or fail to pay premiums on time.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- You change from family to single coverage
- You do not pay premiums on time
- Your coverage as a Participants ends.

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

Continuing Dependent Coverage at Your Death

In the event of your death, your 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 90 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

Surviving spouse does not receive annuity

- Plan coverage may continue after your death when 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 receives annuity

- Plan coverage may continue for each eligible child receiving an annuity larger than the Plan premium
- Member sends payments directly to Plan if annuity is not large enough to cover premium
- Surviving spouses may continue coverage by sending premiums to the Plan

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

- Plan coverage may continue under COBRA provisions
- New dependents or spouses *cannot* be added to survivor's coverage

- Dependent child coverage ends when the child becomes ineligible

Making Changes to Your Retiree Coverage

You can make changes to your coverage only at these time:

- When you have a qualifying event
- During the annual Retiree Option Change Period
    - You may change your Plan option only
    - Adding dependents is not permitted unless you have a qualifying event as described in the section below

Qualifying Events

You can make changes to your coverage if you have a qualifying event. The coverage change must be consistent with the qualifying event.

If you have this event…	You may…
Within 31 days of eligibility for retiree coverage	Change to an available option
Annuity no longer covers premium amount	
Become eligible for Medicare	
Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO)	Change from single to family coverage* Proper documentation is required
Within 31 days of loss of a dependent's health benefit coverage through spouse's or former spouse's Medicaid, Medicare, group or COBRA coverage	
You, your spouse or dependent moves to an area not serviced by the HMO in which you are enrolled	Change to an available option within 31 days of the qualifying event. If the change request is not made within 31 days of the event, your coverage will be transferred automatically to the PPO Option

	Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	Change coverage type within 31 days of the qualifying event; proper documentation is required
	You and spouse are both retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted	Change at any time from family coverage to each having single coverage; a request to change from family to single for you and the request for single coverage for your spouse must be filed at the same time
		**Surviving spouses and dependents cannot change from single to family coverage*

You must request a coverage change within 31 days of the qualifying event by:

- Contacting the Plan directly
- Returning the necessary form(s) with any requested documentation to the Plan by the deadline. Fill out the form(s) completely.

If you miss the deadline, you will not have another change 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.

Changes Permitted Without A Qualifying Event

Retirees may change from family to single coverage, or discontinue coverage at anytime by submitting the appropriate Plan form. However, if you change from family to single coverage, you cannot increase your coverage later without a qualifying event. Also, if you discontinued coverage, you may not enroll later.

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 the PPO Option effective July 1 of the subsequent Plan Year.

Retiree Option Change Period

During the 30-day Retiree Option Change Period – generally from mid-April to mid-May each Plan Year – you can make these changes to your coverage:

- Select a new coverage option
- Change from family to single coverage
- Discontinue coverage (Note that re-enrollments are not allowed.)

Changes will take effect the following July 1.

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

- Information on your 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 Plan always has your most up-to-date mailing address.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, wither 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 and through payroll deduction by your employer. You will need to complete enrollment paperwork.

When you return to retired status, retiree coverage may be reinstated after notifying the Plan within 60 days. You will have 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.

Impact of Medicare on Benefits

Coordination Benefits With 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.

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.

The chart below provides important details related to primary and secondary coverage based on your Medicare status:

If you are retired and …	The Plan will pay…
…age 65, Medicare-eligible* and enroll in Part A and Part B; consider enrolling prior to the month in which you turn 65 to maximize coverage	Secondary benefits starting on the first day of the month in which you turn 65
…age 65, Medicare-eligible* and do *not* enroll in Part A and Part B	Primary benefits
…age 65 or older and not entitled to Medicare	Primary benefits; however, Plan premium will increase

State law specifies that all Plan benefits will be reduced by the full amount of any Medicare benefits to which you and/or your spouse are entitled – regardless of whether or not you are enrolled in Medicare. Therefore, consider enrolling into Medicare as soon as applications are accepted in order to maximize your level of benefit coverage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal Adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
- Loss of eligibility (including, without limitation, legal separation, divorce or death).
- The employer stopped paying the contributions.
- In the case of COBRA continuation coverage, the coverage ended.

Section 5: 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 Network provider, you do not have to file a claim. We pay these providers directly.

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact the Claims Administrator. However, you are responsible for meeting the Annual Deductible and for paying Copayments to a Network 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-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us through United HealthCare. You must file the claim in a format that contains all of the information required, as described below.

To continue reading, go to right column on this page.

You must submit a request for payment of Benefits within one year after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, at United HealthCare's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If a Participant provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Participant. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

A. *Pharmacy Benefit Claims*

If you are asked to pay the full cost of a prescription when you fill it at a retail and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a copayment and you believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim.

If a retail pharmacy fails to fill a prescription that you have presented, you may contact us by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

To continue reading, go to left column on next page.

B. *Required Information*

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

A. A Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:

- Patient Diagnosis
- Date(s) of service
- Procedure Code(s) and descriptions of service(s) rendered
- Charge for each service 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).

C. *Payment of Benefits*

Through United HealthCare, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

A. The provider notifies United HealthCare that your signature is on file, assigning benefits directly to that provider.

To continue reading, go to right column on this page.

D. *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 United HealthCare within 30-days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare 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, United HealthCare 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 (Inpatient Care)

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from United HealthCare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, United HealthCare 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, United HealthCare will

To continue reading, go to left column on next page.

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, United HealthCare will notify you of the 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.

E. *Urgent Claims that Require Immediate Action*

Urgent care 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:

- You will receive notice of the benefit determination in writing or electronically after United HealthCare receives all necessary information, 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, United HealthCare 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, United HealthCare 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.

To continue reading, go to right column on this page.

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

- United HealthCare'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 claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. United HealthCare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

To continue reading, go to left column on next page.

Section 6: Questions 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 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.

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 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 United HealthCare.

To continue reading, go to right column on this page.

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 during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact United HealthCare in writing to formally request an appeal. Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to United HealthCare within 180 days after you receive the claim denial.

To continue reading, go to left column on next page.

Appeal Process – How to Appeal an Eligibility Decision

SHBP will handle all eligibility appeals. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. United HealthCare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

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 How to File a Claim, the first-level appeal will be conducted and you will be notified by United HealthCare 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 United HealthCare 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 How to File a Claim, the first level appeal will be conducted and you will be notified by United HealthCare 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 United HealthCare of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

To continue reading, go to right column on this page.

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 United HealthCare, you have the right to request a second-level appeal from United HealthCare. Your second-level appeal request must be submitted to United HealthCare in writing within 60 days from receipt of the first-level appeal decision.

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

Please note that United HealthCare'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.

To continue reading, go to left column on next page.

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 United HealthCare as soon as possible. United HealthCare will provide you with a written or electronic determination within 72 hours following receipt by United HealthCare of your request for review of the determination taking into account the seriousness of your condition.

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

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Section 7: 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.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays.

To continue reading, go to right column on this page.

Definitions

For purposes of this section, terms are defined as follows:

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.
2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

To continue reading, go to left column on next page.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, an HMO, for example, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:
   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room is not an Allowable Expense, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
   c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
4. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
5. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of

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benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

2) The parents are not separated (whether or not they ever have been married); or

3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Plan Years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1) The Coverage Plan of the custodial parent;

2) The Coverage Plan of the spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

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4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

To continue reading, go to right column on this page.

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits by the total amount of benefits paid or provided by all Coverage Plans primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:
   1. Determine its obligation to pay or provide benefits under its contract;
   2. Determine the difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan and the benefit payments paid or provided by all Coverage Plans primary to this Coverage Plan.

   If there is a difference, this Coverage Plan will pay that amount. Benefits paid or provided by this Coverage Plan plus those of Coverage Plans primary to this Coverage Plan may be less than 100 percent of total Allowable Expenses.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

To continue reading, go to left column on next page.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. SHBP may get the facts it

To continue reading, go to right column on this page.

needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

To continue reading, go to left column on next page.

Section 8: When Coverage Ends

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

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

To continue reading, go to right column on this page.

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 before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

To continue reading, go to left column on next page.

Events Ending Your Coverage

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

For You

Your coverage generally will end if:

- You no longer qualify under any category listed under eligibility and your payroll deductions for coverage have ceased.
- You do not make direct-pay premium payments on time
- You resign or otherwise end your employment
- 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

Coverage for Participant 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.

For Your Dependents

Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. Here are other situations that can affect coverage for you and your dependents.

Situation	Affect on coverage
If enrolled dependent is a stepchild under age 19 and does not meet the 180-day residency requirement	Coverage ends at the end of the month in which dependent moves out
If enrolled dependent is a Full-time Student at an accredited college, university or other institution	Coverage ends on the last day of the month in which the earliest of these events occurs: Graduation or completion of requirements if graduation is delayed Full-time attendance ends – unless child has attended previous tow semesters and plans to return after a one semester break Dependent reaches age 26 Dependent marries Dependent becomes employed in a benefits-eligible position

If you or your spouse or eligible dependent(s) loses other group health insurance coverage because of change in employment	Before you lose coverage or within 31 days after losing coverage, file request for SHBP coverage, which will start on the first day of the month following the request
I you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage	You may enroll yourself or you family if you request this coverage within 31 days of the event

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date SHBP identifies in the notice:

Ending Event	What Happens
Failure to Pay	You failed to pay a required contribution.

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish SHBP with proof of the child's incapacity and dependency within 90 days of the date coverage would otherwise have ended because the child reached a certain age. Before SHBP agrees to this extension of coverage for the child, SHBP may require that a Physician chosen by us examine the child. We will pay for that examination.

SHBP may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 90 days of SHBP's request as described above, coverage for that child will end.

To continue reading, go to right column on this page.

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.

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 Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under Federal Law.
- A Participant's former spouse.

To continue reading, go to left column on next page.

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.

A. Termination of the Participant from employment with us, for any reason other than gross misconduct, or reduction of hours; or
B. Death of the Participant; or
C. Divorce or legal separation of the Participant; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Participant 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 Participant and his or her Enrolled Dependents. This is also a qualifying event for any retired Participant 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 Participant or other Qualified Beneficiary must notify SHBP within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify SHBP of these events within the 60 day period, SHBP is not obligated to

To continue reading, go to right column on this page.

provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under Federal Law, the Participant 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.

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 Participant'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

To continue reading, go to left column on next page.

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 Participant, divorce or legal separation of the Participant, 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 Participant 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 Participant'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 preexisting 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 Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Participant'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 Participant 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.

To continue reading, go to right column on this page.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Plan.

Plan Document

This Summary Plan Description presents an overview of your Benefits. In the event of any discrepancy between this Summary Plan Description and SHBP Summary Plan Description. The rules and regulations of SHBP, or the laws of Georgia, SHBP Summary Plan Description, rules regulations and laws of Georgia shall govern.

Relationship with Providers

The relationships between us, United HealthCare, 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 United HealthCare. 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. 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

To continue reading, go to right column on this page.

employees or employees of United HealthCare; nor do we have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor United HealthCare are liable for any act or omission of any provider.

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

We and SHBP 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 employer and employee, Dependent or other classification as defined in the Plan.

To continue reading, go to left column on next page.

Incentives to Providers

United HealthCare pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives and payment arrangements for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment from United HealthCare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact United HealthCare at the telephone number on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

To continue reading, go to right column on this page.

Incentives to You

Sometimes United HealthCare may offer coupons or other 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 United HealthCare if you have any questions.

Interpretation of Benefits

We and United HealthCare 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.

We and United HealthCare may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

To continue reading, go to left column on next page.

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.

Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

To continue reading, go to right column on this page.

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 coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including United HealthCare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or United HealthCare may need additional information from you. You agree to furnish us and/or United HealthCare 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 United HealthCare with all information or copies of records relating to the services provided to you. We or United HealthCare 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 Participant's enrollment form. We and United HealthCare agree that such information and records will be considered confidential.

We and United HealthCare 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, United HealthCare, and our related entities may use and transfer the

To continue reading, go to left column on next page.

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 United HealthCare 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.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

To continue reading, go to right column on this page.

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, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties").

To continue reading, go to left column on next page.

You agree as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- 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 you will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether or not you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Plan.
- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That we shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and 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.
- We will not pay fees, costs or expenses you incur with any claim or lawsuit, without our prior written consent.

To continue reading, go to right column on this page.

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.

To continue reading, go to left column on next page.

Limitation of Action

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

You cannot bring any legal action against us or United HealthCare 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 United HealthCare 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 United HealthCare.

To continue reading, go to right column on this page.

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Section 10: 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, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse 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 us or SHBP. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

To continue reading, go to right column on this page.

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

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.

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 participants;
- what drugs participants will take;
- what medical tests they will have; and
- how often and what information will be collected.

To continue reading, go to left column on next page.

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 participants 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.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by United HealthCare on our behalf.

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.

To continue reading, go to right column on this page.

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 Participant 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.

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 - the Participant's legal spouse or an unmarried dependent child of the Participant or the Participant's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.

To continue reading, go to left column on next page.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any never married dependent child under 19 years of age.
- A Dependent includes a never married dependent child who is 19 years of age or older, but less than 26 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Participant for support and maintenance.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Facility - a Hospital that United HealthCare names as a Designated Facility. A Designated Facility has entered into an agreement with an organization contracting on our behalf to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within our geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

To continue reading, go to right column on this page.

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

- Can withstand repeated use.
- Is not disposable.
- Is 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 - the amount we will pay for Covered Health Services, incurred while the Plan is in effect, 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 United HealthCare, Eligible Expenses are the fee(s) that are negotiated with the non-Network provider.

To continue reading, go to left column on next page.

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 Dependent - a Dependent who is properly enrolled under the Plan.

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 we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, except for participants that qualify for the Clinical Cancer Trial Services.

To continue reading, go to right column on this page.

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 24 hour nursing services.

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 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.

To continue reading, go to left column on next page.

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.

Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in *Section 1: What's Covered--Benefits*.

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

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

Mental 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 with United HealthCare or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

To continue reading, go to right column on this page.

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 our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other 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 SHBP options. We and SHBP will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount of Coinsurance you pay every calendar 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 calendar year.

Copayments 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;
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

To continue reading, go to left column on next page.

- The Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. 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 Health Benefit Plan.

Plan Sponsor - Georgia Department of Community Health. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

To continue reading, go to right column on this page.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

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

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 - is Georgia Department of Community Health.

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.

To continue reading, go to left column on next page.

Substance Abuse 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.

Mental Health/Substance Abuse Designee - the organization or individual, designated by United HealthCare, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

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 United HealthCare may, in our discretion, determine that an

To continue reading, go to right column on this page.

Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and United HealthCare 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.

To continue reading, go to left column on next page.

Outpatient Prescription Drug Rider

Attachment I

Attachment II

Choice Plan

for

Georgia Department of Community Health

Outpatient Prescription Drug Rider

Group Number: 702030
Effective Date: July 1, 2005

Table of Contents

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.

When we use the words "we," "us," and "our" in this document, we are referring to the 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 10: Glossary of Defined Terms*.

NOTE: The Coordination of Benefits provision *Section 7: Coordination of Benefits* in the Summary Plan Description does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

To continue reading, go to right column on this page.

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Introduction

Coverage Policies and Guidelines

United HealthCare's Pharmacy and Therapeutics Committee is the national committee which reviews all drugs that are newly approved by the FDA. The Pharmacy and Therapeutics Committee evaluates the use of the newly approved prescription drug. The Pharmacy and Therapeutics Committee objectively evaluates drugs for therapeutic treatment and safety. The evaluation includes, but is not limited to: safety and efficacy; supply limits; notification requirements. The Pharmacy and Therapeutics Committee makes recommendations to United HealthCare's Preferred Drug List Management Committee for final approval. This two-step process is designed to establish coverage policies and guidelines that promote quality and cost-effective drug therapy.

Even after a drug is included on the Preferred Drug List, this evaluation continues at least annually or as new information becomes available.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

To continue reading, go to right column on this page.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Summary Plan Description *Section 5: 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 the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Limitation on Selection of Pharmacies

If we determine that you are 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.

Coupons and Incentives

At various times we may offer coupons or other incentives for certain drugs on the Preferred Drug List. Only your doctor can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

To continue reading, go to left column on next page.

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 Order or Refill 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 or is prescribed to prevent conception.

When a Brand Name Drug Becomes Available as a Generic

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by use, please review the definitions contained in *Section 3: Glossary of Defined Terms* at the end of this Rider. You should also check the current classification on the Preferred Drug List through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card.

To continue reading, go to right column on this page.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type 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 United HealthCare has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may obtain a current list of Prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card. The list is subject to periodic review and modification.

Notification Requirements

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

- It meets the definition of a Covered Health Service.

To continue reading, go to left column on next page.

- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification. When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying United HealthCare.

The list of Prescription Drug Products requiring notification is subject to periodic review and modification. You may obtain a current list of Prescription Drug Products that require notification through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card.

If United HealthCare is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the Summary Plan Description *Section 5: How to File a Claim*.

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

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed.

What You Must Pay

You are responsible for paying the applicable Copayment described in the *Benefit Information* table when Prescription Drug Products are obtained from a Network Pharmacy.

To continue reading, go to right column on this page.

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:

- Copayments for Prescription Drug Products.
- 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 and our contracted rates (our Prescription Drug Cost) will not be available to you.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.***

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits 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. (Except for maintenance medication). • As written by the provider, two copays for 90-day supply of a Maintenance Drug Product, determined by DCH and United HealthCare. • A one cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay two Copayments.	**Coverage up to 31-day supply**: $10 per Prescription Order or Refill for a **Generic Prescription Drug Product.** $25 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on the Preferred Drug List.** $50 per Prescription Order or Refill for a **Brand-name Prescription Drug Product which is not on the Preferred Drug List.** **Coverage from 32-day to 90-day supply**: $20 per Prescription Order or Refill for a **Generic Prescription Drug Product.** $50 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on the Preferred Drug List.** $100 per Prescription Order or Refill for a **Brand-name Prescription Drug Product which is not on the Preferred Drug List.**

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. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
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. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.
5. 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.
6. 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'

To continue reading, go to right column on this page.

compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

7. Any product dispensed for the purpose of appetite suppression and other weight-loss products.
8. A specialty medication Prescription Drug Product (such as immunizations) which, due to its characteristics as determined by us, 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 Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single-entity vitamins.
11. Unit-dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
14. Prescription Drug Products when prescribed to treat infertility.
15. Prescription Drug Products for smoking cessation.
16. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. 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, except as required to treat symptoms related to viral infections causing the common cold.

To continue reading, go to left column on next page.

18. New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Pharmacy and Therapeutics Committee and approved by our Preferred Drug List Management Committee.
19. Growth-hormone therapy, with the exception of diagnostic testing to rule out a diagnosis. Once diagnosed growth-hormone therapy is not covered.

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Section 3: Glossary of Defined Terms

This section:

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

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 we identify as a Brand-name product. A Prescription Drug Product is classified as a Brand-name based on available data resources, such as 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 a Brand-name by us.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that we identify as a Generic product. Classification of a Prescription Drug Product as a Generic is determined by us and not by the manufacturer or pharmacy. A Prescription Drug Product is classified as a Generic based on available data resources, such as 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 us.

To continue reading, go to right column on this page.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with United HealthCare 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 us as a Network 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 approved by United HealthCare's Preferred Drug List Management Committee.
- December 31st of the following calendar year.

Preferred Drug List - a list that identifies those Prescription Drug Products that are preferred by us for dispensing to Covered Persons when appropriate. This list is subject to our periodic (at least quarterly) review and modification. Contact United HealthCare at the telephone number on your ID card to obtain a copy of the current Preferred Drug List or you can access it through the Internet at www.myuhc.com or www.365wellst.com.

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

To continue reading, go to left column on next page.

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 Order or Refill. 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:
- insulin syringes with needles;
- blood testing strips - glucose;
- urine testing strips - glucose;
- ketone testing strips and tablets;
- lancets and lancet devices;
- insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
- insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
- glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

To continue reading, go to right column on this page.

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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 Copayments 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.

To continue reading, go to right column on this page.

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require than a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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Attachment II

Summary Plan Description

Name of Plan: Georgia Department of Community Health Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Georgia Department of Community Health – State Health Benefit Plan
#2 Peachtree 35th floor
Atlanta, GA 30303

(404) 651-6141

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 58-1282972

IRS Plan Number: 501

Effective Date of Plan: July 1, 2005

Type of Plan: Group health care coverage plan

To continue reading, go to right column on this page.

Name, Business address, and Business Telephone Number of SHBP:

Georgia Department of Community Health – State Health Benefit Plan
#2 Peachtree 35th floor
Atlanta, GA 30303

(404) 651-6141

Claims Administrator: The company which provides certain administrative services for the Plan.

United HealthCare Insurance Company

P.O. Box 150450

450 Columbus Blvd.

Hartford, CT 06115-0450

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

To continue reading, go to left column on next page.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as United HealthCare. The Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is Georgia Department of Community Health, the Plan Sponsor.

Person designated as agent for service of legal process: Service of process may also be made upon SHBP.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan Year shall be a six-month period ending December 31.

To continue reading, go to right column on this page.

Determinations of Qualified Medical Child Support Orders.

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to SHBP.

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and condition, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have

To continue reading, go to left column on next page.

creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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