

Scott County

A SUMMARY PLAN DESCRIPTION

**Scott County's managed care
health benefits plan administered by
UnitedHealthcare Services Company of the River Valley, Inc.**

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FOREWORD

This Summary Plan Description outlines the benefits adopted by ABC Company and provided to Members in Scott County's self-funded, managed care health benefits plan (Plan) in the following classes:

UnitedHealthcare Services Company of the River Valley, Inc. (UnitedHealthcare) has been selected by Scott County to administer this Plan. UnitedHealthcare does not insure this Plan. The Company is responsible for paying for the benefits provided to You and Your Eligible Dependents. Under the terms of this Plan You may be responsible for payment of some of those benefits.

This booklet describes Your benefits in a general way and is subject to the terms and conditions of the Administrative Services Agreement between the Company and UnitedHealthcare.

IMPORTANT DEFINITIONS

Following are definitions of terms that have a specific meaning when they are used to describe Your Plan:

Allowed Charge – the portion of a charge for a service or supply that UnitedHealthcare will consider in calculating benefits. The Allowed Charge is determined as follows:

1. For services received from a Participating Provider, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract.
2. For services received from a non-Participating Physician as a result of a Medical Emergency or with a Preauthorized Referral, the Allowed Charge is the non-Participating Physician's reasonable and customary charge. The Member is not responsible for the difference between the Physician's charge and the reasonable and customary charge. For services received from a non-Participating provider which is a hospital or a facility as a result of a Medical Emergency or with a Preauthorized Referral, the Allowed Charge is the non-Participating provider's billed charge.
3. For services received from a non-Participating provider as a result of using the "self-referral" option, the Allowed Charge is the reasonable and customary charge. The Member is responsible for the difference between the non-Participating provider's billed charge and the reasonable and customary Charge.

Reasonable and customary means the portion of any charge that is within the amount charged for similar services and supplies in the area where the charge is made. Reasonable and customary is determined by using data from the Health Insurance Association of America (HIAA), which collects fee information based on zip codes from insurance companies covering more than 95 million individuals. Reimbursement is based on the 80th percentile of HIAA profiles.

Appeal - a Complaint, which, having been reported to UnitedHealthcare by the Member and remaining unresolved to the Member's satisfaction, is filed for formal proceedings as set forth in the section entitled, *Complaint, Appeal and Dispute Resolution Procedures*.

Authorized Representative - a Member's guardian or an individual the Member has authorized to act on his or her behalf, including but not limited to the Member's Physician.

Clinical Peer - a health care professional who is the same profession and same or similar specialty as the health care provider who typically manages the medical condition, procedures or treatment under review.

Coinsurance – percentage of the Allowed Charge that the Member must pay for services received. The percentage is described in the section entitled, *Medical Benefits Summary*.

Complaint - an oral or written expression of dissatisfaction relating to the policies of or the services provided by the Plan.

Concurrent Care Decision - a reduction or termination of a previously approved ongoing course of treatment (provided over a period of time or for a specified number of treatments) before the end of such period of time or number of treatments.

Copayment – the amount, if any, the Member must pay for each medical service received, such as a doctor office visit. The amount is specified per service and is shown in the section entitled, *Medical Benefits Summary*. Each Copayment shall be paid at the time the service is provided.

Deductible – the amount the Member must pay for health services before the Plan begins to pay. The amount is shown in the section entitled, *Medical Benefits Summary*. Any charges in excess of Reasonable and Customary, whether or not paid by the Member, will not apply to the Deductible. Furthermore, if any supplemental benefits rider is attached to this SPD, such as but not limited to prescription drug, dental, vision or hearing, amounts paid by the Member in connection with any of those supplemental benefits will not apply toward any applicable Deductible as shown in the section entitled *Medical Benefit Summary*.

Eligible Dependent - a person who meets the Plan's eligibility requirements set forth in this Summary Plan Description.

ERISA - Employee Retirement Income Security Act (The Act of 1974.)

Home Health Services – care, when a Member is confined to his or her home related to an illness or injury, which is ordered by the Participating Physician, approved in advance by UnitedHealthcare, and is provided by a Home Health Agency.

Home Health Agency – a public or private agency that specialize in providing nursing services in the home; is licensed to operate as a Home Health Agency under applicable state or local laws; and has a contractual relationship with UnitedHealthcare.

Medical Emergency - the sudden and unexpected onset of conditions requiring medical care which You secure immediately after the onset or as soon thereafter as the care can be made available. The condition must be of such nature that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failure to render care and/or treatment at the time required could result in deterioration to the point of placing the Member's life in jeopardy and/or cause serious impairment to bodily functions of the Member. Benefits for continuing or follow up care pursuant to a Medical Emergency will be provided subject to all the provisions of the Plan.

Member - You and Your Eligible Dependents who are enrolled in this Plan.

Participating Physician - a duly licensed Physician who has entered into a contractual arrangement with UnitedHealthcare for the provision of health care services to Members.

Participating Provider - any Physician, hospital, extended care facility, individual, organization or agency which has a contractual arrangement with UnitedHealthcare for the provision of health care services to Members.

Out-of-Pocket Maximum – the sum total amount of Copayments, Coinsurance, and Deductibles, as shown for an individual or family in the section entitled, *Medical Benefits Summary*, and paid by a Member, after which – for the remainder of the calendar year – the Plan will pay 100% of the Allowed Charge for that Member's subsequent health care services covered under the Plan. However, if any supplementary benefits are covered under the Plan, such as but not limited to prescription drug, dental, vision, or hearing, the amounts paid by the Member in connection with any of those supplementary benefits will not apply toward the Out-of-Pocket Maximum.

Physician - a person licensed and acting within the scope of that license to practice medicine or perform surgery.

Post-Service Claim - any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim - any claim for a benefit in which UnitedHealthcare conditions the receipt of the benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

Preauthorized Referral - written authorization provided by a Primary Care Physician for medically necessary covered services from: (1) a Participating Provider other than a Primary Care Physician; or (2) a Non-Participating Provider. The Participating level of payment will be made only if the referral is obtained from a Primary Care Physician and approved by UnitedHealthcare prior to the time services are provided, except in the event of a Medical Emergency.

Primary Care Physician - a Participating Physician, licensed to practice medicine, who has been identified in writing by UnitedHealthcare as a Primary Care Physician, whose practice is devoted to internal medicine, family/general practice, obstetrics/gynecology, or pediatrics. The Primary Care Physician You select will coordinate all of Your medical care.

Summary Plan Description - the written document adopted by the Company which outlines the coverage, limitations, exclusions, and responsibilities contained in this Plan.

Urgent Care Claim - any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or b) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

You/Your - an employee who is eligible to participate in the health benefit plan offered by the Company as set forth in this Summary Plan Description and who has enrolled hereunder.

ENROLLMENT AND TERMINATION POLICIES AND PROCEDURES

Selecting Your Primary Care Physician

If Your personal Physician is a Participating Physician, You may continue to see him/her. If You or Your Eligible Dependents have been seeing a doctor who is not a Participating Physician, You will be required to change to a Participating Physician in order to receive Plan benefits.

Please select Your Primary Care Physician from the provider directory that was given to You at the time of enrollment. He/She will help You coordinate all of Your medical care – from routine physicals to referrals to specialist. If You do not have a provider directory, You may request one, free of charge, by contacting the toll-free UnitedHealthcare Member Service number listed on the back of Your Plan ID card.

Note: A provider's listing in the provider directory does not guarantee that the provider is still in the Participating or accepting new Members. Please call the toll-free UnitedHealthcare Member Service number listed on the back of Your Plan ID card to see if a particular provider is in the Participating.

Enrollment/Disenrollment/Special Enrollment

Each year during the open enrollment period You have the opportunity to decide whether You wish to continue enrollment in the Plan. You will be informed by Your Human Resources Department of any procedures You must follow. However, if You decide to disenroll or add family members, You must complete an Enrollment Change Form. These forms are available through Your Human Resources Department.

Special Enrollment. UnitedHealthcare shall provide a special enrollment period during which an eligible individual may enroll for coverage under this Plan under certain conditions. For purposes of the section, the term "special enrollment period" means a period of thirty-one (31) days during which an eligible employee is allowed to enroll him/herself and/or any Eligible Dependents upon the occurrence of certain events and conditions as described below:

1. Prior coverage terminated or exhausted. A special enrollment period is available due to loss of other group coverage or other health insurance coverage as described below:

A. Coverage loss which creates special enrollment opportunity. Special enrollment is available to persons specified in Section 1.B. when

- (1). COBRA continuation coverage with a prior carrier is exhausted; or
- (2). Coverage under another group health plan or other health insurance coverage, which is not COBRA continuation coverage, has terminated as a result of: a) loss of eligibility through legal separation, divorce, death, termination of employment or reduction in the number of hours worked; or b) cessation of employer contributions.

B. Persons who may be entitled to special enrollment due to loss of prior coverage. A special enrollment period will be allowed for the persons described below when a loss of coverage described in Section 1.A. has occurred, and if enrollment takes place during the special enrollment period:

- (1). For an eligible employee, upon losing coverage under another plan.
- (2). For an Eligible Dependent, upon losing coverage under another plan, but only if such individual is an Eligible Dependent of an employee who is already covered under this Plan.

(3). For both the eligible employee and the employee's Eligible Dependent, if either loses coverage under another plan because of any of the following: (1) no longer lives or works in an HMO service area if no other benefit option is available; (2) the plan no longer offers benefits to a class of individuals that include the eligible employee and/or Eligible Dependent; (3) eligible employee and/or Eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits; or (4) the eligible employee and/or Eligible Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required premium within 60 days of the date coverage ended.

C. In order to enroll due to loss of coverage as described above, the following conditions must be met:

(1). The individual must be eligible to enroll under this Plan; *and*

(2). Coverage for the individual was declined under this Plan when the person first became eligible; *and*

(3). When coverage was previously declined, the individual was covered under another group's health plan or other health coverage; *and*

(4). The employee stated in writing to UnitedHealthcare (if UnitedHealthcare required such a statement) that the existence of other coverage was the reason for declining enrollment for employee and/or Eligible Dependent.

(5)The employee previously declined coverage under the contract, but the employee and/or dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required premium within 60 days of the date of determination or subsidy eligibility.

D. Special Enrollment Period for Loss of Coverage for Section 1. To enroll due to loss of coverage, the employee must apply for coverage for employee and/or dependent within thirty-one (31) days of the loss of coverage unless otherwise noted above.

2. Acquisition of a Dependent. A special enrollment period will be allowed for the persons described below when the described events occur, and if they enroll during the special enrollment period stated in Section 2.F.:

A. For an employee who is eligible but not enrolled: when he/she marries or has a new child as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship or placement for adoption or determination of eligibility for state subsidy;

B. For an individual who becomes a spouse of a Member: at the time of marriage, or when a child becomes an Eligible Dependent of that Member as the result of birth, adoption, interim court order for adoption or legal guardianship or placement for adoption or determination of eligibility for state subsidy;

C. For both an employee who is eligible but not enrolled and an eligible spouse: when they marry or when a child becomes an Eligible Dependent of a Member as a result of birth, adoption, interim court order for adoption or legal guardianship or placed for adoption or determination of eligibility for state subsidy;

D. For a child: upon becoming an Eligible Dependent of a Member as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption or determination of eligibility for state subsidy;

E. *For both an employee who is eligible but not enrolled and a child:* when the child becomes an Eligible Dependent of the employee as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption or determination of eligibility for state subsidy;

F. *Special Enrollment Period for Section 2.* The employee must apply for coverage for the employee and/or an Eligible Dependent within thirty-one (31) days from the date of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption or determination of eligibility for state subsidy unless otherwise noted above.

3. *Effective Date of Enrollment.* For those enrolled during a special enrollment period, enrollment is effective as follows:

A. *Loss of Coverage.* In the case of prior coverage being terminated or exhausted, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

B. *Marriage.* In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

C. *Birth.* In the case of an Eligible Dependent's birth, on the date of such birth.

D. *Adoption, Interim Court Order for Adoption or Legal Guardianship, or Placement for Adoption.* In the case of an Eligible Dependent's adoption, interim court order for adoption or legal guardianship or placement for adoption on the date of such adoption, interim court order for adoption or legal guardianship or placement for adoption.

4. For purposes of counting creditable coverage, the enrollment date for anyone who enrolls under a special enrollment period is the first day of coverage. That is, the time between the dates an individual becomes eligible for enrollment under this Plan and the first day of coverage is not treated as a waiting period.

Dependent Eligibility

Eligible Dependents who are enrolled at the same time as you, have coverage the same day your coverage begins.

Eligible Dependents are:

- 1) Your Spouse, as defined by the laws of Iowa.
- 2) Domestic Partner as per employer's policy.
- 3) Your unmarried dependent children up to age 25, who is not a full-time student. Coverage terminates on the coverage anniversary date on or after the child:
 - a) marries;
 - b) ceases to be a resident of Iowa; or
 - c) reaches age 25;whichever comes first.
- 4) Your unmarried child, regardless of age, who maintains full-time student status in an accredited institution of postsecondary education. Coverage terminates on the policy anniversary date on or after the unmarried child ceases to be a full-time student.
- 4) Your unmarried child, regardless of age, who is all of the following:

- a) permanently and totally disabled, if the disability occurred while an Eligible Dependent as defined in 2) or 3) above;
- b) incapable of self-sustaining employment; and
- c) chiefly dependent upon the Subscriber or other care providers for support.

The term “child” means a natural born or legally adopted child, a child who has been placed with the Subscriber for adoption, a stepchild who lives with the Subscriber, a child who is under the Subscriber’s legal guardianship pursuant to a valid order of a United States federal or state court, or a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court of administrative order, even if the child does not reside within the Service Area.

UnitedHealthcare may require that the Subscriber furnish proof of continued dependency of any unmarried child or other dependent.

Eligible Dependent Permanently Residing Outside the Plan Service Area.

If your Eligible Dependent child permanently resides outside the Plan Service Area because of a separation, divorce or other reasons and if that dependent cannot use Network Providers for certain medical care, you should not enroll in the Plan. In such cases, you should discuss the health care alternatives available with your Human Resources Department.

Identification (ID) Cards

As a Plan Member, You will receive a Plan identification (ID) card. The card identifies You and Your Eligible Dependents and lists the identification numbers needed for the coding of Your claims, including Your Member number and a two-digit sequence number for each covered person.

Possession of a Plan ID card does not entitle You to benefits unless You are a current covered Member.

The information on Your ID card identifies You as a Plan Member. Your ID card gives Physicians and providers information outlining Your health care benefits. Presenting Your ID card to Physicians, hospitals and other providers will help eliminate billing errors.

Initially, two ID cards will be sent to You. If You need additional ID cards, please call the toll-free UnitedHealthcare Member Service number on the back of Your ID card. You will be given the option to access an automated system to order ID cards.

Termination of Coverage

The Plan may terminate You or an Eligible Dependent for any one of the following reasons:

1. Fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under such circumstances, the Plan shall have the right to recover the full amount of any benefits paid on behalf of You or an Eligible Dependent.
2. If You allow use of Your Plan ID card by someone other than an Eligible Dependent.
3. For failure to pay Participating Copayments, Coinsurance, and/or Deductibles.
4. If You or an Eligible Dependent refuse to follow the treatment program as established by a Participating Physician(s). This will only occur after consultation with UnitedHealthcare, You and, if applicable, Your Eligible Dependent.

5. If You or an Eligible Dependent no longer meet the eligibility requirements the Company has established.
6. For failure of the Company to make the contribution payment. Only Members for whom the Company has paid the contribution to UnitedHealthcare shall be entitled to benefits for the period for which the payment has been received. If the contribution is not received during any grace period granted by UnitedHealthcare, coverage may be terminated at the end of the grace period with prior notice to the Company but without prior notice from UnitedHealthcare to You and Your Eligible Dependents. If this happens, the Company and/or You and Your Eligible Dependents may be held liable for benefits received during the grace period, and amounts uncollected from the Company may be collected from You and Your Eligible Dependents.
7. Death of the employee. Upon the death of the employee this Plan shall automatically terminate. See Continuation of Coverage
8. Expiration of the maximum continuation of coverage period.

A certificate of creditable coverage will be provided in accordance with federal law. Also, a Member may request a certificate of creditable coverage by contacting UnitedHealthcare at the appropriate address or toll-free telephone number listed in the section entitled *John Deere Health Care Inc. Offices*

CONTINUATION OF COVERAGE

(Consolidated Omnibus Budget Reconciliation Act - COBRA)

Introduction

This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.** This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should contact the Plan Administrator.

The Company or its delegate is the Plan Administrator, as designated in the section entitled *ERISA Information*. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage unless other arrangements have been made through the Company.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens: (1) Your hours of employment are reduced, or (2) Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens: (1) Your spouse dies; (2) Your spouse’s hours of employment are reduced; (3) Your spouse’s employment ends for any reason other than his or her gross misconduct; (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or (5) You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any of the following qualifying events happens: (1) The parent-employee dies; (2) the parent-employee’s hours of employment are reduced; (3) The parent-employee’s employment ends for any reason other than his or her gross misconduct; (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); (5) The parents become divorced or legally separated; or (6) The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Company provides retiree health coverage, the following may apply:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Please contact the Plan Administrator for more information.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, (if Plan provides retiree coverage) or enrollment of the employee in Medicare (Part A, Part B, or both). The

employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events or within 30 days following the date coverage ends, whichever is applicable.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on either the date of the qualifying event or the date that Plan coverage would otherwise have been lost, whichever is applicable.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), Your divorce or legal separation, or a dependent child losing eligibility as a dependent child, Your COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**
If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator.
- **Second qualifying event extension of 18-month period of continuation coverage**
If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to an Eligible Dependent child when that child stops being eligible under the Plan as an Eligible Dependent child. **In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.**

If You have questions

If You have questions about Your COBRA continuation coverage, You should contact Your Plan Administrator as designated in the section entitled *ERISA Information* or You may contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. The toll-free telephone number is 1/866/275-7922.

Keep Your plan informed of address changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

PARTICIPATING & NON-PARTICIPATING POLICIES & PROCEDURES

How the Plan Works

Benefits will be paid only for services which are medically necessary. Medically necessary criteria are explained in *Important Coverage Restrictions*.

Under this Plan Your employer is providing health care coverage for You and Your Eligible Dependents with the use of Primary Care Physicians and a carefully selected panel of specialists. The following chart gives an overview of how the Plan works.

Care Received From	Benefits Paid At
Primary Care Physician	Higher Benefit Level
Specialist or other provider with a Preauthorized Referral	Higher Benefit Level
Specialist or other provider without a Preauthorized Referral	Self-Referral Benefit Level

Receiving care from Your Primary Care Physician ensures that Your benefits will be paid at the higher benefit level. Your Primary Care Physician is best qualified to determine what services are medically necessary for Your care. The following health care services **must** be received from Your Primary Care Physician or with a Preauthorized Referral to a Participating Provider, or benefits **will not** be paid:

1. Preventive care examinations and all associated services, including laboratory and X-ray examinations performed in conjunction with the preventive care examination for people age seven (7) and above.
2. Immunizations for people age seven (7) and above.
3. Allergy testing and injections.
4. Durable medical equipment and prosthetic devices.
5. Home health services.
6. Organ transplant services.

Mental health and substance abuse treatment is provided through contracts with selected providers. In order to receive benefits for these services, You and Your Eligible Dependents must be evaluated by a selected provider prior to commencement of treatment. See the back of Your ID card for the phone number of Your mental health/substance abuse treatment program coordinator. Covered services include:

1. All physician services for mental health and substance abuse treatment.
2. All facility services for mental health and substance abuse treatment.
3. Psychological testing.

Prescription drugs are covered as stated in the section entitled, *Supplemental Benefits*, and if You have Your prescriptions filled at a Participating pharmacy.

If You receive care from Your Primary Care Physician or have a Preauthorized Referral to another provider, You will be responsible only for any applicable Copayments/Coinsurance, Deductibles, and fees for non-covered services. If You choose to access care without a Preauthorized Referral, Your benefits will be paid at the lower self-referral benefit level and You will be responsible for any applicable Copayments/Coinsurance, Deductibles, fees in excess of reasonable and customary, and as always, fees for non-covered services. The exceptions to this rule are in the event of a Medical Emergency or when there is a Preauthorized Referral in place. In a Medical Emergency You may seek services from any licensed provider and benefits for those services will be paid at the higher benefit level.

Preauthorized Referrals

When You are covered by this Plan, Your health care will be coordinated by Your Primary Care Physician. If specialized care is required, Your Primary Care Physician will arrange for a Preauthorized Referral.

Referral to Specialists

There may be times when you will need the care of a specialist. For this reason, a panel of local Physicians will be available to provide Members with specialty care. Examples of specialties are: Allergy, Cardiology, Cardiovascular Surgery, Dermatology, Gastroenterology, General Surgery, Infectious Disease, Internal Medicine, Oncology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Pediatric Cardiology, Podiatry, Psychiatry, Pulmonary Disease, Radiology, Rehabilitation, Rheumatology and Urology.

When Your Primary Care Physician determines that You need specialized care, You and Your Primary Care Physician together will choose a specialist from the panel. An appointment will then be scheduled for You. The specialist will work closely with Your Primary Care Physician to ensure that the care provided is consistent with, and appropriate for Your needs.

In most cases, specialized services are available from Participating Providers. However, if the care You need is not available from Participating Providers, Your Primary Care Physician will call UnitedHealthcare for a Preauthorized Referral which, upon evaluation by UnitedHealthcare, may allow You to see a non-Participating provider.

Participating Physicians who represent various medical specialties serve as Physician advisors and review the medical information supplied by Your Primary Care Physician. Based on this review, a decision is made as to whether non-Participating provider care is medically necessary. Your Primary Care Physician will be notified by telephone as to approval or denial. Additionally, both You and Your Primary Care Physician will receive a letter from UnitedHealthcare advising of the approval or denial.

If the request for a Preauthorized Referral is denied, You or Your Authorized Representative can Appeal this decision by using the procedures described under the section entitled, *Complaint, Appeal and Dispute Resolution Procedures*. We also encourage You to contact Your Participating Physician for further direction of Your care.

If Your referral is approved, Your letter, called a Preauthorized Referral, will list the referral's effective dates and the kind of care and services You are authorized to receive. UnitedHealthcare will also send the non-Participating provider a copy of Your Preauthorized Referral letter.

Once a Preauthorized Referral expires, it is Your responsibility to notify Your Primary Care Physician so that he/she can determine whether further non-Participating care is needed and, if so, request another Preauthorized Referral through UnitedHealthcare.

On occasion, a non-Participating provider You have been referred to may direct You to yet another non-Participating provider. If this happens, You should contact Your Primary Care Physician to make sure that he/she is aware of the additional treatment before it is received. If the additional treatment is necessary, Your Primary Care Physician will need to request another Preauthorized Referral through UnitedHealthcare.

Note: All referrals for the health care services listed above provided by other than Your Primary Care Physician must be approved in advance by UnitedHealthcare prior to the time services are received. The only exception to this rule is in the event of a Medical Emergency. Care required to treat and stabilize a Medical Emergency will be covered at the same level as services received through Your Primary Care Physician, regardless of whether or not a treating doctor or hospital is a Participating Provider.

How the Self-Referral Option Works

Under the self-referral option, You may use any licensed provider You choose for some of Your health care needs. As explained in the previous section, *How the Plan Works*, not all services are eligible for coverage under the self-referral option. Please refer to that section for the list of services that must be received from Your Primary Care Physician or with a Preauthorized Referral. You are responsible for making arrangements for Your care and for submitting claims for reimbursement.

Benefit payment will be made subject to the Deductible and the applicable Out-of-Pocket Maximum percentage(s) shown in the *Medical Benefits Summary*. The self-referral option begins to pay benefits for Allowed Charges only after a Deductible is met. Before self-referral benefits are payable You must first pay a portion of the Allowed Charges out of Your pocket.

Not all benefits available under the Plan are eligible for self-referral coverage. If a service must be provided by Your Primary Care Physician or arranged or approved in advance by Your Primary Care Physician to be received from a Participating Provider and You use a non-Participating provider, the charges You incur will not be applied to Your Deductible or Out-of-Pocket Maximum and no benefits will be paid.

Claim Filing Procedures

Procedures for Urgent Care Claims

UnitedHealthcare will make a coverage decision within 72 hours after receipt of the request for an Urgent Care Claim. UnitedHealthcare will attempt to reach You or Your Authorized Representative by telephone or facsimile as soon as a decision has been made. . Written confirmation of UnitedHealthcare's decision will be mailed to You or Your Authorized representative within 3 calendar days.

If additional information is needed to evaluate Your claim, You or Your Authorized Representative will be notified within 24 hours after receipt of the claim specifying what information is needed to make a decision. When the additional information is received, a decision will be made by UnitedHealthcare within 48 hours after receipt of the specified information or the end of the period given to provide the specified information, whichever is earlier.

Procedures for Pre-Service Claims (Non-Urgent Care Claims)

UnitedHealthcare will make a coverage decision and notify You or Your Authorized Representative in writing within 15 calendar days after receipt of the request for a Pre-Service Claim.

If additional information is needed to make a decision, You or Your Authorized Representative will be advised of the specific information needed within 15 calendar days of the receipt of a Pre-Service Claim. You or Your Authorized Representative will be notified in writing of the reason(s) for the extension. You or Your Authorized Representative will have 45 calendar days from the receipt of the written notice to provide the additional information, and UnitedHealthcare will make a decision within 15 calendar days after the earlier of the receipt of the needed information or the end of the 45-day period.

The Pre-Service Claim determination period may also be extended one time for 15 calendar days due to circumstances beyond the control of UnitedHealthcare. You or Your Authorized Representative will be notified in writing of the reason(s) for the extension.

Procedures for Concurrent Care Decisions

Concurrent Care Decisions to reduce or terminate coverage for ongoing treatment will be provided in writing to You far enough in advance for You or Your Authorized Representative to Appeal the decision and obtain a determination before the termination or reduction goes into effect.

Any request by You to extend the course of treatment involving urgent care, will be decided as soon as possible taking into account the medical circumstances. UnitedHealthcare will notify You of the determination, adverse or not, within 24 hours after receipt of the claim, provided the claim is made at least 24 hours prior to the expiration of the treatment. Urgent Care Claims received by UnitedHealthcare less than 24 hours prior to the expiration of the treatment will be handled according to the procedures described in the section entitled, *Procedures for Urgent Care Claims*.

Concurrent Care Decisions involving non-urgent care claims will be handled according to the procedures described in the sections entitled, *Procedures for Pre-Service Claims & Procedures for Post-Service Claims*.

Procedures for Post-Service Claims

UnitedHealthcare will make a coverage decision within 30 calendar days after the receipt of a claim for payment or reimbursement of health care services that have already been provided. When coverage is denied, You or Your Authorized Representative will be notified in writing.

If additional information is needed to make a decision, You or Your Authorized Representative will be advised of the specific information needed within 30 calendar days of the receipt of a Pre-Service Claim. You or Your Authorized Representative will be notified in writing of the reason(s) for the extension. You or Your Authorized Representative will have 45 calendar days from the receipt of the written notice to provide the additional information, and UnitedHealthcare will make a decision within 15 calendar days after the earlier of the receipt of the needed information or the end of the 45-day period.

The Post-Service Claim determination period may also be extended one time for 15 calendar days due to circumstances beyond the control of UnitedHealthcare. You or Your Authorized Representative will be notified in writing of the reason(s) for the extension.

Other Important Claim Filing Information

If a charge is made to You by a Participating Provider for a service covered under this Summary Plan Description beyond any applicable Copayments, Coinsurance and Deductibles, written proof of these charges should be furnished to UnitedHealthcare within 90 calendar days from the date of service. Payment for such charges will not be made to You if evidence of payment is submitted more than fifteen months after the date of service.

Participating Providers

Participating Providers will bill UnitedHealthcare directly.

Non-Participating Providers

Preauthorized Referrals

Present Your UnitedHealthcare Preauthorized Referral form along with Your Plan ID card to the admissions area when You arrive for Your scheduled appointment. Inform the facility that UnitedHealthcare should be billed directly.

Should the referral provider have any questions concerning billing, ask the provider to contact UnitedHealthcare at the toll-free telephone number printed on the back of Your Plan ID card. UnitedHealthcare will work out the details for reimbursement with them.

Self-Referrals

You will be responsible for payment of all expenses which satisfy the Deductible and Out-of-Pocket Maximum provisions under the self-referral option. You will also be responsible for payment of any fees in excess of reasonable and customary fees and fees for any non-covered services.

If You decide to self-refer You may need to pay the bill Yourself and obtain an itemized statement which includes a diagnosis, the service date, a description of services received (including procedure codes) and the provider's name, address and telephone number. Send this statement to UnitedHealthcare attached to a note that includes Your Plan ID number, Your home address, a daytime telephone number where You can be reached and a brief explanation of the situation.

Benefit payment for self-referral services will be made to You. If You wish direct payment to be made to the non-Participating provider, a benefit assignment will need to be attached to the claim. Direct provider payment does not transfer Your right to Appeal, right to representation or any other rights You may have under the Plan.

Medical Management Processes

UnitedHealthcare may apply the following medical management processes to the self-referral option as well as to the Participating coverage:

Preauthorization

Some procedures, including certain medical and diagnostic procedures, require approval by UnitedHealthcare prior to You receiving the service (preauthorization). Established criteria are used to determine the appropriateness of the services and level of care to be provided. If You have questions whether a specific procedure is covered by your Plan, please call UnitedHealthcare Member Service at the toll-free number listed on the back of Your Plan ID card. Under the self-referral option, failure to obtain preauthorization may result in the Member's being responsible for the costs of the procedure and any associated expenses.

Hospital or Nursing Facility Admission Review

When You or Your Eligible Dependent is admitted to a Participating hospital or skilled nursing facility, that facility or Your Primary Care Physician will notify UnitedHealthcare of the admission. However, if You or Your Eligible Dependent is admitted to a non-Participating facility without preadmission notification, UnitedHealthcare must be notified within 24 hours of admission by calling the toll-free number on the back of Your Plan ID card. If You or Your Eligible Dependent fail to make this notification, and the facility stay is longer than medically necessary, You will be responsible for all charges associated with all non-covered days. These charges will not be applied to any Deductible or Out-of-Pocket Maximum expense limits.

Hospital or Nursing Facility Continued Stay Review

Continued stay at a facility will be reviewed for the appropriate level in inpatient care and length of treatment. This review will be performed by UnitedHealthcare. If medical necessity is no longer clear, UnitedHealthcare may contact Your Primary Care Physician to determine the need for the continued stay and request a plan of treatment. Any services provided, following the determination that services are not medically necessary, will not be paid and charges for such services will not be applied to any applicable Deductible or Out-of-Pocket Maximum expense limits.

Case Management

UnitedHealthcare may engage in the medical management of certain treatment of Members from time to time to help assure that appropriate health care is being provided to the Member. This medical management may also coordinate various aspects of care provided to seriously ill or injured Members.

Out-of-Pocket Maximums

Participating

Some of the services provided by Primary Care Physicians and other Participating Providers require Copayment or Coinsurance. Under the Participating benefit level, Copayment or Coinsurance is the amount You must pay before the Plan pays the balance of an Allowed Charge in full.

There is a calendar year maximum to the amount of Copayment/Coinsurance/Deductible that You will be required to pay for health care You receive from Your Primary Care Physician and other Participating Providers on both an individual and family basis.

The Individual Out-of-Pocket Maximum

The individual Out-of-Pocket Maximum for Participating services is listed in the *Medical Benefits Summary*. Once a Member has reached the individual Out-of-Pocket Maximum, Participating Provider benefits are paid in full for that person for the rest of the calendar year. Ordinarily, the individual Out-of-Pocket Maximum must be met in order for Participating Provider benefits to begin to be paid at 100%. There is one exception to the individual Out-of-Pocket Maximum provision and that is the family Out-of-Pocket Maximum.

The Family Out-of-Pocket Maximum

There is a family Out-of-Pocket Maximum listed in the *Medical Benefits Summary*. After a family has reached the family Out-of-Pocket Maximum, Allowed Charges will be paid in full for all subsequent Participating Provider services received by all covered family members for the rest of the calendar year. Once the family maximum has been met, the individual Out-of-Pocket Maximum is waived.

Notice of Restriction

Please note that Deductible and Copayments/Coinsurance costs incurred when You use the self-referral option do not apply to the Participating option Out-of-Pocket Maximum. Supplemental Copayments also do not apply to the Participating option Out-of-Pocket Maximum.

There is no carryover to the following calendar year of any Participating services Out-of-Pocket Maximum expenses incurred during the fourth calendar quarter of the current year.

Self-Referral

There is a maximum to the amount of allowable self-referral out-of-pocket expenses You will be required to pay during the calendar year.

The Individual Out-of-Pocket Maximum

The individual self-referral Out-of-Pocket Maximum is listed in the *Medical Benefits Summary*. Once the individual self-referral Out-of-Pocket Maximum is satisfied, Allowed Charges for self-referral services are paid at 100% for the remainder of the calendar year. There is an exception to the individual Out-of-Pocket Maximum provision and that is the family Out-of-Pocket Maximum.

The Family Out-of-Pocket Maximum

The family self-referral Out-of-Pocket Maximum is listed in the *Medical Benefits Summary*. After a family has reached the family self-referral Out-of-Pocket Maximum, the Plan will pay subsequent Allowed Charges for self-referral services at 100%. This maximum is a total accumulation of Allowed Charges paid out-of-pocket and incurred by all covered family members. Each family member need not meet their individual Out-of-Pocket Maximum in order for the family Out-of-Pocket Maximum to be met and for subsequent Allowed Charges incurred by any family member to be paid at 100%.

Notice of Restriction

Please note that Deductible and Copayments/Coinsurance costs incurred when You use Your Primary Care Physician or preauthorized Participating Provider do not apply to the self-referral option Out-of-Pocket Maximum. Supplemental Copayments also do not apply to the self-referral Out-of-Pocket Maximum.

There is no carryover to the following calendar year of any self-referral Out-of-Pocket Maximum expenses incurred during the fourth quarter of the current year.

Deductibles

Network

Before Participating benefits are payable, You must first pay a portion of the Allowed Charges out of Your pocket to satisfy the Deductible.

The Individual Deductible

The individual Deductible is listed in the *Medical Benefits Summary*. Charges that are applied to this Deductible are Allowed Charges for network services. The individual Deductible must be satisfied before benefit payment begins. There is one exception to the individual Deductible requirement and that is the family Deductible.

The Family Deductible

The family Deductible is listed in the *Medical Benefits Summary*. After the Deductible amount is satisfied, UnitedHealthcare will begin to pay benefits for all covered family members. This Deductible maximum is a total accumulation of Allowed Charges applied to the individual Deductibles of covered family members. Each family member need not meet his or her individual Deductible in order for the family Deductible to be met.

Deductible Carry Over Feature

Any portion of the per person network Deductible met during the last three months of the calendar year (October, November, December) will be credited to that person's network Deductible requirement for the following calendar year.

Self-Referrals

Before self-referral benefits are payable, You must first pay a portion of the Allowed Charges out of Your pocket to satisfy the Deductible.

The Individual Deductible

The individual Deductible is listed in the *Medical Benefits Summary*. Charges that are applied to this Deductible are Allowed Charges for self-referral services. The individual Deductible must be satisfied before benefit payment begins. There is one exception to the individual Deductible requirement and that is the family Deductible.

The Family Deductible

The family Deductible is listed in the *Medical Benefits Summary*. After the Deductible amount is satisfied, the Plan will begin to pay benefits for all covered family members. This Deductible maximum is a total accumulation of Allowed Charges applied to the individual Deductibles of covered family members. Each family member need not meet their individual Deductible in order for the family Deductible to be met.

Deductible Carry Over Feature

Any portion of the per person self-referral Deductible met during the last three months of the calendar year (October, November, December) will be credited to that person's self-referral Deductible requirement for the following calendar year.

UnitedHealthcare Plan of the River Valley, Inc.

Medical Benefits Summary

Benefits	Member Responsibility	
	Network	Point of Service
Deductible (Contract Year)	None	\$200 individual \$400 family
Maximum Out-of-Pocket Expense (Contract Year)	\$1,000 individual \$2,500 family	\$1,500 individual \$3,000 family
Lifetime Benefit Maximum	<u>\$5,000,000</u>	
4th Quarter Deductible Carryover	<u>Applicable</u>	
Physician Medical Services		
Allergy Injections.....	\$0 copayment	Not covered
Allergy Testing.....	\$20 copayment/visit	Not covered
Home Visits.....	\$20 copayment/visit	20% after deductible
Immunizations.....	\$0 copayment	20% coinsurance+*
Injections – Physician Office.....	\$0 copayment	20% after deductible
Inpatient Hospital Visits & Consultations.....	\$20 copayment/visit	20% after deductible
Maternity Care.....	\$100 copayment/pregnancy	20% after deductible
Newborn Baby Care.....	\$20 copayment/visit	20% coinsurance+
Nursing Facility Visits.....	\$20 copayment/visit	20% after deductible
Office Visits.....	\$20 copayment/visit	20% after deductible
Outpatient Physician Services.....	\$20 copayment/visit	20% after deductible
Routine/Preventive Physical Exam.....	\$20 copayment/visit	20% coinsurance+*
Surgical Services – Inpatient.....	\$100 copayment/surgery	20% after deductible
Surgical Services – Outpatient.....	\$100 copayment/surgery	20% after deductible
Surgical Services – Office.....	\$20 copayment/surgery	20% after deductible
Well Child Care.....	\$20 copayment/visit	20% coinsurance+*
Urgent Care Center	\$20 copayment/visit	20% after deductible
Emergency Services		
Ambulance.....	\$0 copayment	\$0 copayment+
Emergency Room Facility	\$75 copayment/visit	\$75 copayment/visit+
Emergency Room Physician Care.....	\$20 copayment/visit	\$20 copayment/visit+
<i>Initial care only of a Medical Emergency is covered. Follow up care obtained in the emergency room is not covered. Emergency room facility Copayment will be waived if admitted.</i>		
Hospital/Facility Services		
Inpatient Hospital (Semi-Private Room).....	\$100 copay/admission	20% after deductible
Outpatient Facility or Surgi-Center Services.....	\$50 copayment	20% after deductible
Nursing Facility (Limited to 100 days per contract year).....	\$0 copayment	20% after deductible
Home Health Care	\$0 copayment	Not covered
<i>Must be approved in advance by UnitedHealthcare</i>		

Benefits

Member Responsibility

	Network	Point of Service
Medical Equipment		
Durable Medical Equipment•Prosthetic Devices.....	\$0 copayment	Not covered
Outpatient Rehabilitative Therapy		
Physical•Speech•Occupational	\$0 copayment	20% after deductible
<i>Member is limited to 60 outpatient treatment days per contract year. Speech therapy will only be covered for residual speech impairment resulting from a stroke, accidental injury, or surgery to head or neck.</i>		
Radiation Therapy and Chemotherapy		
Hospital (Outpatient).....	\$0 copayment	20% after deductible
Office.....	\$0 copayment	20% after deductible
X-Ray and Laboratory Service		
Hospital (Outpatient).....	\$0 copayment	20% after deductible
As part of routine/preventive physical exam	\$0 copayment	20% coinsurance+*
Office.....	\$0 copayment	20% after deductible
As part of routine/preventive physical exam	\$0 copayment	20% coinsurance+*
Mental Health Services		
Inpatient Facility.....	\$100 copay/admission	20% after deductible
Inpatient Physician Visits	\$20 copayment/visit	20% after deductible
Outpatient Facility	\$50 copayment/admission	20% after deductible
Outpatient Physician Services	\$20 copayment/visit	20% after deductible
Office Visits	\$20 copayment/visit	20% after deductible
Substance Abuse Services		
Inpatient Facility	\$100 copay/admission	20% after deductible
Inpatient Physician Visits	\$20 copayment/visit	20% after deductible
Outpatient Facility	\$50 copayment/admission	20% after deductible
Outpatient Physician Services	\$20 copayment/visit	20% after deductible
Office Visits.....	\$20 copayment/visit	20% after deductible

Definitions

Copayment: The amount the member must pay for each medical service received, such as a physician office visit.

Coinsurance: The percentage of cost that the member must pay for services received.

Deductible: The amount the member must pay for health services, before the health plan begins to pay.

Maximum Out-of-Pocket Expense: The sum total amount of co-payments, coinsurance and deductibles, as shown above for an individual family and paid by the member, after which—for the remainder of the contract year—the health plan will pay 100% of the allowed charge for that member's subsequent covered health care services. However, amounts paid by the member in connection with any supplemental benefit riders will not apply toward the maximum out-of-pocket expense. NOTE: The network and point of service maximum out-of-pocket expense is not combined.

Exclusions and Limitations

Non-covered benefits include, but are not limited to: services not medically necessary • experimental procedures or personal or convenience items • custodial care • cosmetic services or surgery • reversal of sterilization • infertility services • food or food supplements • over-the-counter drugs • dental • vision • hearing • and prescriptions drugs (unless covered by supplemental benefit plan).

Note

- When multiple services are performed, the member may be subject to multiple copayments and/or coinsurance in addition to any applicable deductible.
- “Preventive Care” refers to routine/physical examinations and services recommended by the U.S. Preventive Services Task Force.

Prescription Drug Benefits At-A-Glance

Benefit Features Member

Responsibility

Prescription Drugs

Generic Equivalent (<i>Low Drug Copayment</i>)	\$5 copayment
Formulary Brand Name (<i>Medium Drug Copayment</i>)	\$15 copayment
Non-Formulary Brand Name or Compounded Prescriptions (<i>High Drug Copayment</i>)	\$30 copayment

Birth Control

Generic Equivalent (<i>Low Drug Copayment</i>)	\$5 copayment
Formulary Brand Name (<i>Medium Drug Copayment</i>)	\$15 copayment
Non-Formulary Brand Name or Compounded Prescriptions (<i>High Drug Copayment</i>)	\$30 copayment

Diabetic Supplies

Insulin Syringes	\$5 copayment
Test strips, lancets, glucose monitors	Refer to your medical benefits (<i>reference Durable Medical Equipment</i>)

Definitions

Formulary Brand Name: A listing of brand name outpatient prescription drugs selected on the basis of effectiveness and cost.

This list is subject to periodic review and modification.

Generic Equivalent: A chemically equivalent form of a brand name drug for which the patent has expired. You pay the lowest

drug copayment when you receive a generic drug.

Non-Formulary Brand Name: Brand name outpatient prescription drugs outside of UnitedHealthcare's formulary.

Application of Drug Copayments

Drug copayments for outpatient prescription drugs do not apply toward the medical maximum out-of-pocket expense or deductible, if applicable.

Limitations

Prescription quantity shall be limited to the amount ordered by the attending physician. Quantity per prescription fill or refill

shall not exceed a 30-day supply or such other day supply as authorized by UnitedHealthcare. However, items on the 90-day

supply list may be dispensed in quantities up to a maximum of 90-day supply through mail order and three (3) copayments for each 90-day supply through retail. UnitedHealthcare reserves the right to establish criteria and require prior

authorization

for certain outpatient prescription drugs.

Benefit Exclusions

Non-covered items include, but are not limited to: medications available over the counter (OTC), unless (1) such OTC medication has been designated by UnitedHealthcare as eligible for coverage as if it were an outpatient prescription drug, and

(2) such OTC medication is obtained with a prescription from an attending physician • growth hormone • therapeutic or prosthetic devices • drugs used for cosmetic purposes • drugs used to enhance physical or mental performance • treatment or

supplies to promote smoking cessation • dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional formulas and supplements • drugs used for the treatment of infertility • drugs used for experimental purposes.

This document is provided as a brief summary and is not intended to be a complete description of the benefit plan. After you become covered, you will be issued an evidence of coverage (Subscriber Agreement or Summary Plan Description) describing your coverage in greater detail. The evidence of coverage will govern the exact terms, conditions, and scope of coverage. In the event of a conflict between this *Prescription Drug Benefits At-A-Glance*, and the evidence of coverage, the language of the evidence of coverage controls.

Covered Services

Note: The following covered services are described in a general way. Please refer to the section entitled *Medical Benefits Summary* for specific benefit payment amounts, guidelines, and restrictions. If You have further questions regarding specific services or procedures, call the toll-free UnitedHealthcare Member Service number listed on the back of Your Plan ID card.

Network Only Services

The following services *must* be obtained from Your Primary Care Physician or from a non-participating Physician with a Preauthorized Referral (except in a Medical Emergency) or benefits *will not* be paid:

1. Preventive care examinations and all associated services, including laboratory and X-ray examinations performed in conjunction with the preventive care examination for people age seven (7) and above.
2. Immunizations for people age seven (7) and above.
3. Allergy testing and injections.
4. Durable medical equipment and prosthetic devices.
5. Home health services.
6. Organ transplant services.

Mental health and substance abuse treatment is provided through a Participating of selected treatment program providers. In order to receive benefits for these services, You and Your Eligible Dependents must be evaluated by a selected provider prior to commencement of treatment, except on the event of a Medical Emergency, or benefits will not be paid. See the back of Your Plan ID card for the phone number of Your mental health/substance abuse treatment program coordinator. Covered services include:

- All physician services for mental health and substance abuse treatment received inpatient, outpatient or in an office setting.
- All inpatient, outpatient and office facility services for mental health and substance abuse treatment.
- Psychological testing.

If this Plan includes prescription drug coverage as stated in the section *Supplemental Benefits*, prescription drug coverage is available if You have Your prescription filled at a Participating pharmacy, except in the case of a Medical Emergency.

Preventive Care Examinations and Associated Services

If You are seven (7) and above, You must always utilize Your Primary Care Physician for preventive care examinations (routine physicals, well child care, and routine Pap tests), as well as for such services which may be ordered in conjunction with the examination, such as immunizations, laboratory and X-ray examinations. Preventive care examination and associated services received under the self-referral option **will not** be covered. . “Preventive care” refers to services recommended by the U.S. Preventive Services Task Force. Note: Routine preventive examinations and associated services for persons 6 years of age or younger are covered under the “point of service” option described in the section entitled *How the Self-Referral Option Works*.

Organ Transplant Services

All organ transplant services **must** be ordered by Your Primary Care Physician or a Participating Provider to whom the Primary Care Physician has authorized a referral, approved in advance by UnitedHealthcare and received from transplant centers approved by UnitedHealthcare or benefits will not be paid. However, cornea transplants may be ordered by and performed by a Participating Provider that is not a UnitedHealthcare approved transplant center.

Benefit payment for organ transplant services is subject to any maximums and limitations set for the benefit type rendered. For example, hospital room benefits would be limited to a semiprivate or intensive care room - a private room would not be covered unless approved as medically necessary by UnitedHealthcare.

Transplant services for a Member who is the recipient of an organ or tissue transplant include all professional, technical and facility charges (inpatient and outpatient) for evaluation and the transplant procedure and follow up care (12 months). If the recipient is a Member, medically necessary professional, technical and facility charges for removal of the donated organ or tissue, as well as any direct complication resulting from the donation, are also covered by UnitedHealthcare for a live primary donor up to 90 calendar days after the date of the donation, unless such donation is covered by other insurance.

Organ and tissues covered for transplants include, heart, heart/lung, kidney, kidney/pancreas, liver, lung, bone marrow and stem cell. The Member’s Primary Care Physician or a Participating Provider to whom the Primary Care Physician has authorized a referral of the Member must contact UnitedHealthcare for coordination of a referral to a transplant center approved by UnitedHealthcare prior to the time services are rendered, except for cornea transplants.

Prosthetic Devices

If an injury or illness causes loss or impairment of a bodily organ, the Plan will provide benefits for replacement parts called prosthetic devices.

Prosthetic devices **must** be prescribed or arranged by Your Primary Care Physician and must be obtained or repaired from a Participating Provider, or benefits **will not** be paid.

Prosthetic devices are those devices which replace all or part of a body organ, including contiguous tissue, or a diseased, malformed or injured part of the body, or replace all or part of the function of a permanently inoperative or malfunctioning bodily organ or portion of the body.

Prosthetic devices are such items as:

- Braces - leg, arm, back.
- Artificial legs, arms, eyes, larynxes, external breast prostheses.
- Replacement of unusable covered prosthetic devices.
- Trusses and scoliosis appliances.
- Colostomy supplies, bags and sets.
- Ostomy and urinary sets and other limited supplies.

- Post-surgical lenses customarily used during convalescence from eye surgery in which the eye's lens has been removed.

The prosthetic device benefit does not include such items as:

- Dentures and other dental appliances.
- Eyeglasses and other lenses to correct visual defects.
- Special shoes, unless an integral part of a leg brace.
- Hearing aids.
- Wigs or hairpieces.
- Vehicle or home alterations.
- Enhancements to devices which are patient preference or patient convenience and not medically necessary for use of the device.

Benefits are payable for initial placement of a prosthetic device and its supportive device; maintenance and repair required for the successful use of the device; replacement of a device when required by growth or change in medical condition; and, replacement of a device when medically necessary and due either to wear and tear or to technological improvement.

Durable Medical Equipment

Benefits are available under the Plan for the rental of durable medical equipment prescribed for home use in the treatment of an injury or illness or for the improvement of the function of a malformed body member.

In some cases, UnitedHealthcare may determine that purchase of the equipment is more appropriate than rental.

Durable medical equipment **must** be prescribed or arranged by Your Primary Care Physician and obtained from a Participating Provider or benefits **will not** be paid.

Durable medical equipment is medical equipment which can withstand repeated use; is primarily and customarily used to serve a medical purpose; is not useful in the absence of illness or injury; and is appropriate for home medical treatment.

Durable medical equipment includes such items as:

- Crutches, canes, walkers.
- Inhalers.
- Traction devices.
- Glucose monitors.
- Hospital type beds.
- Oxygen tents.
- Toilet aids.
- Neuromuscular stimulator.
- Wheelchairs.

Durable medical equipment **does not** include such items as:

- Air conditioners.
- Room heaters, humidifiers.
- Dehumidifiers or vaporizers.
- Heat lamps, whirlpool baths.
- Elastic stockings, girdles, corsets, suspensories.
- Any equipment which basically supplies comfort or convenience.
- Enhancements above and beyond what are medically necessary for operation of the durable medical equipment.

Home Health Care

Home health care services are those medically necessary services rendered to a homebound patient that are related to the treatment of certain medical conditions.

All home health care requests **must** be ordered by Your Primary Care Physician and preauthorized by UnitedHealthcare and received from a Participating Provider, or benefits **will not** be paid.

Home health care benefits are **not** paid when benefits are payable under other parts of this Plan, or for private duty or shift coverage.

Home health care services will not be covered beyond the medically necessary time period specified by Your Primary Care Physician.

Allergy Testing and Injections

All allergy testing and injections must be received from Your Primary Care Physician. Services received from a self-referral option **will not** be covered.

TMJ Syndrome Benefit

Treatment of temporomandibular or craniomandibular joint syndrome or disorders (hereafter “TMJ syndrome”) is limited to services which are medically necessary in connection with fractures, neoplasms, rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, and acute dislocation of the mandible (but not dislocation of the cartilage without dislocation of the mandible) from direct and extrinsic trauma. All services for TMJ syndrome must be ordered by Your Primary Care Physician and provided by a Participating Provider or with a Preauthorized Referral. Osteotomy is not a covered treatment for TMJ syndrome.

Mental Health and Substance Abuse Services

Benefits for mental health and substance abuse, including alcoholism are provided **only** through a network of selected treatment program providers. For benefits to be paid, You or Your Eligible Dependents must be evaluated by the selected provider prior to commencement of treatment, except in the case of a Medical Emergency. Services for mental health/substance abuse treatment are obtained by calling the phone number on the back of Your ID card. You will reach a mental health/substance abuse treatment coordinator who will direct You to a selected provider.

Benefits are payable for inpatient, outpatient and office visits when You or Your Eligible Dependent receives psychiatric or professional services from a selected provider acting within the scope of his or her licensed authority or other licensed mental health provider for a psychiatric, mental or nervous condition or disorder for alcoholism or substance abuse.

Note: Treatment of a medical complication resulting from abuse of or addiction to alcohol or drugs shall not count toward any of the substance abuse maximums shown under this heading. Payment for medical complications will be made as for any other illness. **There is no self-referral option for mental health or substance abuse services.**

Mental Health and Substance Abuse benefits are not payable for:

1. Treatment of mental retardation or untreatable mental deficiency.
2. Learning disorders.

3. Mental disorders which are not likely to improve through accepted psychiatric treatment.
4. Antisocial behavior or aggressive or non-aggressive conduct disorder unless there is an associate psychiatric disorder.
5. Diversionary activities.
6. General counseling and advice, including marriage counseling.
7. Court-ordered psychiatric services unless medically necessary and approved in advance by the mental health/substance abuse treatment program provider.

Network and Non-Network Benefits

Physician Medical Services

Benefits are available for the following services rendered by either Your Primary Care Physician or through the use of the self-referral option when performed for the treatment of illness or injury:

1. Office visits.
2. Office consultations.
3. Injections (does not include allergy injections or immunizations for people age seven (7) and above. These must be received from Your Primary Care Physician or benefits *will not* be paid).
4. Home visits and visits to a skilled nursing facility.
5. Inpatient hospital visits and inpatient consultations.
6. Radiation therapy.
7. Chemotherapy.

Physician Surgical Services

Benefits are available for a physician's surgical services when rendered by either Your Primary Care Physician or through the use of the self-referral option whether the surgery is performed in a Physician's office, outpatient at a hospital or inpatient in a hospital.

Benefits are also available for medically necessary services received in connection with surgical procedures performed in ambulatory surgical centers which are licensed as surgical centers by the state.

Diabetes Self-Management

Benefits are provided for equipment and supplies (blood glucose monitors and supplies including those for the legally blind), regular foot care examinations, and outpatient self-management training and education, including medical nutritional therapy, for treatment of insulin-dependent, insulin-using, gestational and non-insulin using diabetes. Outpatient self-management training and education must be provided in person by a certified, registered or licensed health care professional which is part of a UnitedHealthcare approved diabetes education program.

Hospital and Skilled Nursing Facility Services

Hospital

Benefits are available for services received in an acute care hospital for room and board at the semi-private or intensive care level. A private room is covered only when approved as medically necessary. Room and board includes all charges made by a hospital on its own behalf for the room, meals and for all general services and activities needed for the care of a registered bed patient.

Also covered are the miscellaneous medical services and supplies used during the confinement such as, but not limited to, diagnostic X-ray and laboratory examinations, the cost and administration of anesthesia, whole blood and blood derivatives.

Hospital services for medical treatment *must* be authorized by either Your Primary Care Physician or through the use of the self-referral option.

Skilled Nursing Facility

If you no longer need hospital services but Your Physician recommends 24-hour nursing care or therapy in a skilled nursing facility, your Plan benefits can continue.

Benefits are payable for semi-private room and board as well as services and supplies charged by the skilled nursing facility and furnished for Your use while You are confined.

Skilled nursing facility services must be authorized by either Your Primary Care Physician or through the use of the self-referral option.

For purposes of this document, a skilled nursing facility means an extended care facility which has been designated a skilled nursing facility by UnitedHealthcare and is accredited under applicable state law or is recognized and eligible for payment under the Medicare Act.

Emergency Room Care

If an illness or injury is obviously life threatening, go directly to the emergency room. Visits to the emergency room should not be used as a substitute for care that can be received in Your Primary Care Physician's office during regular business hours. In-area emergency room care covers only initial care of a Medical Emergency.

If time permits, call Your Primary Care Physician who knows Your health history. Your telephone call enables him/her to determine the necessary course of treatment - whether it be advising the emergency room staff, meeting You in the emergency room to treat You personally or asking You to schedule an office visit.

If Your Primary Care Physician is not available, consider the following "Medical Emergency" criteria:

1. The condition must be one that could result in death or serious damage if not treated right away.
2. Symptoms must occur suddenly and unexpectedly and must require prompt medical attention.
3. Medical assistance must be sought immediately after the condition has occurred.

Here are some examples of a Medical Emergency:

A blocked airway.	Heat stroke.
A collapsed lung.	High fever.
A heart attack.	Appendicitis.
A blood clot.	Shock.
Severe loss of blood.	Loss of consciousness.
Kidney failure.	

Some accidents or illnesses are obviously life threatening and thus require immediate emergency care. In other cases, You may not be sure whether an illness or injury constitutes a Medical Emergency. Remember that a chronic condition in which symptoms have existed over a period of time does not generally constitute a Medical Emergency. However, if the symptoms become acute enough to require immediate medical assistance, a Medical Emergency may exist. Symptoms such as high fever or severe abdominal pain are sometimes indications of life threatening illness. In such cases consult Your Primary Care Physician.

If it is determined by UnitedHealthcare that a Medical Emergency did not exist, or that services were not medically necessary, You will be held financially responsible for those services. As a general rule, the date of the onset of symptoms and the date of treatment as reported on the claim form should be the same but not more than 24 hours after an illness or injury.

Ambulance Services

Ambulance Services are covered:

- 1) for Medical Emergencies.
- 2) for non-emergencies, only when medically necessary.

Maternity and Newborn Benefits

Maternity

Maternity care includes prenatal and post-natal care and care for complications of pregnancy. Coverage with regards to post-delivery care includes a minimum of 48 hours of inpatient care following a vaginal delivery for the mother and the newborn and a minimum of 96 hours of inpatient care following a delivery by caesarian section for the mother and newborn.

A shorter length of stay for services related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn.

The Plan will pay for maternity care in the same way that it pays for an illness.

Covered maternity expenses include:

1. Physician care for the mother, including the charges for office care during the pregnancy and delivery related charges.
2. Hospital care for the mother.
3. Medically necessary X-ray and laboratory services.

Newborn

If the newborn qualifies as an Eligible Dependent, benefits will be payable for expenses incurred by the newborn in the same way as for an illness.

Covered newborn expenses include:

1. Hospital nursery care.
2. Physician care, including charges for circumcision.

Outpatient Rehabilitative Therapy

Outpatient rehabilitative therapy benefits will be paid for conditions resulting from disease or injury or when prescribed immediately following surgery related to the condition. Rehabilitative therapy includes physical, occupational and/or speech therapy. Therapy may be authorized by either Your Primary Care Physician or a non-Participating provider. Physical therapy must be performed by a licensed physical therapist as defined as follows:

- A physical therapist means a person who is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent and, where applicable, is licensed.

Physical therapy includes functional occupational therapy performed by an occupational therapist to the extent that the therapy is performed to regain use of the upper extremities. Benefits are not payable for vocational therapy, vocational rehabilitation, educational or recreational therapy.

Speech therapy benefits will be covered for a residual speech impairment resulting from a stroke, accidental injury or surgery to the head or neck. Speech therapy must be authorized by either Your Primary Care Physician or a Participating Provider with a Preauthorized Referral or by a non-Participating Physician through the self-referral option and must be performed by a speech therapist as defined as follows:

- Speech therapist means an audiologist who possesses a master's or doctorate degree in audiology and speech pathology from an accredited university, a Certificate of Clinical Competence in audiology from the American Speech and Hearing Association, and who is licensed by the state (where required).

Certain limitations apply to the number of physical, occupational and speech therapy visits payable per disability. See the *Medical Benefits Summary* under the heading *Outpatient Physical/Occupational/Speech Therapy Services* for the maximum benefits payable.

X-ray and Laboratory Services

The Plan provides benefits for diagnostic X-ray and laboratory services performed for diagnosis and/or treatment of an illness or injury.

Diagnostic X-ray and laboratory services include, but are not limited to, X-ray films and scans, such as computerized axial tomography (CAT) scans, electrocardiograms (EKGs), ultrasound examinations, mammography and blood, urine and pathology (tissue) test.

Radiation Therapy and Chemotherapy

Benefits are payable for:

1. Radiation therapy (such as x-ray and radium) received in connection with the treatment of malignancies and certain other tumors.
2. Chemotherapy received for the treatment of malignancies.

Reconstructive Surgery

Benefits are provided for medically necessary reconstructive surgery when such service is incidental to or follows surgery which has resulted in a functional defect as a result of trauma, infection or other disease of the involved part and for medically necessary reconstructive surgery because of a congenital disease or anomaly which has resulted in a functional defect in an Eligible Dependent child.

In connection with a mastectomy for which the Member is receiving benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

Please refer to the section entitled, *Exclusions Applicable to the Entire Plan*, for services that may not be covered.

EXCLUSIONS APPLICABLE TO THE ENTIRE PLAN

The Plan does not provide coverage for the following:

1. Any service or treatment which is not medically necessary, as described and defined in the section entitled, *Important Coverage Restrictions* or any medical complication resulting from a treatment, procedure, or device which is not covered under this Plan.
2. Shift care, 24-hour nursing, private or special duty nursing services in the hospital, home or skilled nursing facility, unless determined to be medically necessary and authorized by UnitedHealthcare.
3. Care for conditions that federal, state or local law requires be treated in a public facility, hospital or other health care facility.
4. Treatment provided in a government hospital; services performed by a Member for a Member's immediate family; and services for which no charge is normally made.
5. Services for any illness, injury or disease that is covered in whole or part, by any employer's plan or coverage designed to comply with any state or federal workers' compensation, employer's liability or occupational disease law (collectively, workers' compensation law), or, with respect to the Member, any illness, injury or disease that could be covered, in whole or in part, by such a plan or coverage if the employer had such a plan or coverage. If UnitedHealthcare makes payment for such services it shall be entitled to a lien upon any amounts it paid for which the employer's workers' compensation law plan or coverage should have been liable.
6. Custodial care which means that care consists of watching, maintaining, protecting, or is for the purpose of providing personal needs rather than being able to cure. If You or Your Eligible Dependent's condition requires care which is considered custodial, Plan benefits do not provide the following:
 - a. Assistance in the activities of daily living, such as walking, dressing, getting in and out of bed; bathing, feeding or using the toilet or help with other functions of daily living or personal needs of a similar nature.
 - b. Changes of dressings, diapers, protective sheets or periodic turning or positioning in bed.
 - c. Administration of, or help in using or applying, medications, creams and ointments, whether oral, inhaled, topical, rectal or injected.
 - d. Administration of oxygen.
 - e. Care or maintenance in connection with casts, braces or other similar devices.
 - f. Care in connection with ostomy bags or devices or indwelling catheters.
 - g. Feeding by tube, including cleaning and care of the tube site.
 - h. Tracheostomy care, including cleaning, suctioning and site care.
 - i. Urinary bladder catheterization.
 - j. Monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function, including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer.
 - k. General supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitative services.

Exception to the above exclusion: Psychiatric Medical Institute for Children (PMIC) admissions shall be treated as an acute inpatient hospitalization if a child diagnosed with a biologically based mental illness meets the Medicaid criteria for

PMIC admission. Such medically necessary benefits will not be excluded or denied as care that is substantially custodial in nature.

7. Hospital, personal or convenience items such as TV, telephone, newborn infant photos, complimentary meals, birth announcements and other articles which are not for specific treatment of illness or injury. Also, benefits are not provided for private room or special diets unless medically necessary; housekeeping, homemaker services and caregiver room/board; purchase or rental of household equipment or fixtures such as air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, waterbeds, escalators, elevators, saunas or swimming pools.
8. Surgical excision or reformation of any sagging skin on any part of the body including but not limited to eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with enlargement, reduction, implantation, or change in appearance in any portion of the body including but not limited to, breasts, face, lips, jaw, chin, nose, ears or genitals; hair transplantation; chemical face peels or abrasions of skin; electrolysis depilation; treatment of birthmarks or superficial veins; any other surgical or non-surgical procedures which are performed for cosmetic purposes; and any complications of such procedures. Please refer to the section entitled, *Reconstructive Surgery* for covered services.
9. Services of non-physician Participating Providers if the charges are claimed by hospitals, laboratories, or other institutions; services of any assisting Physician not authorized by a Participating Physician.
10. Any fees involving any types of services in connection with dentistry; including but not limited to, the care, filling, removal or replacement of teeth or of the structures supporting the teeth. Surgical augmentation for orthodontics or maxillary (upper jaw) or mandibular (lower jaw) construction. Orthognathic surgery, which refers to any surgical procedure performed to correct skeletal malposition or misalignment of the maxilla and/or mandible, including osteotomy or condylotomy. Coverage for medically necessary treatment of temporomandibular or craniomandibular joint syndrome (TMJ) is explained in the section entitled, *TMJ Syndrome Benefit*.

Exceptions to this exclusion are as follows:

- a. Reconstructive surgery as provided in the section entitled, *Reconstructive Surgery*;
 - b. Approved surgical and non-surgical procedures resulting directly from neoplasms that require treatment to the jaws, cheeks, lips, tongue, or roof or floor of mouth and injury to natural permanent teeth. "Injury" does not include fractures of restorations or teeth resulting from routine daily functions. A Preauthorized Referral will be required if such treatment is performed by a non-Participating provider; and
 - c. If dental coverage is provided under this Plan as set forth in this Summary Plan Description under *Supplemental Benefits*.
11. Surgery to the cornea to improve vision by changing the refraction such as, but not limited to, radial keratotomy or LASIK (laser assisted in-situ keratomileusis), or any complications therefrom.
 12. Special shoes, unless an integral part of a brace or part of diabetes treatment; foot orthotic devices and supplies unless part of diabetes treatment; routine foot care including trimming of corns, calluses and nails, unless part of diabetes treatment; corsets, other articles of clothing or cosmetic devices.
 13. Any service which can be performed in the setting by a person who does not have professional qualifications but has been trained to perform the service.
 14. Experimental and/or investigational drugs, devices, medical treatments or procedures, including any complications arising therefrom. Experimental and/or investigational means:

- a. The drug or device requires approval of the Food and Drug Administration and the drug or device has not been approved when furnished (a drug or device approved for investigational use is deemed to be experimental or investigational); or,
- b. Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials for the Member's medical condition except for National Cancer Institute-approved phase III clinical trials for cancer; or,
- c. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis for the Member's medical condition.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature.

- 15. Biofeedback, except in conjunction with physical therapy performed for the treatment of urinary incontinence.
- 16. Holistic medicine; massage therapy, acupuncture; hypnotherapy; sleep therapy; vocational, rehabilitational or employment counseling; marriage and sex counseling; behavior training, conduct disorders and related family counseling; remedial education and treatment of learning disabilities.
- 16. Ergometers, exercise bicycles, or similar equipment or devices.
- 17. Diet or weight loss programs, nutritional counseling, dietary supplements, nutritional formulas and supplements and megavitamin therapy. Exceptions to this exclusion are as follows:
 - a.) Medical nutritional therapy will be covered for up to two medically necessary visits per calendar year for hypertension and myocardial infarction; or
 - b.) Medical nutritional therapy will be coverage under a diabetes self-management program as described in the section entitled *Diabetes Self-Management*.
- 18. Illness contracted or injuries sustained as the result of war, declared or undeclared, or any act or hazard of war.
- 19. Illness contracted or injuries sustained as the result of, or while in, the armed services of any country, if You or Your Eligible Dependent are entitled to coverage for such illness or injury through any governmental plan or program except Medicaid.
- 20. Hospital or Physician services or treatment provided as a result of a court order, unless approved in advance by Primary Care Physician.
- 21. Any treatment or procedures relating to the performance of gender transformation, including any complications arising therefrom.
- 22. Any health care services which are coverable under a mandatory automobile no-fault plan.
- 23. Long-term physical therapy and rehabilitation.
- 24. Drugs, medicines or any implants or devices used in conjunction with birth control, regardless of the intended use.
- 25. Charges incurred in connection with: (a) any testing or procedure to support a diagnosis of infertility; or (b) any assisted reproduction techniques such as, but not limited to, artificial insemination and in vitro fertilization, reversal of vasectomies, reversal of tubal ligations or the reversal of other voluntary sterilization procedures unless provided under *Supplemental Benefits* OR Charges incurred in connection with reversal of vasectomies, reversal of tubal ligations or the reversal of other voluntary sterilization procedures.

26. Physical exams and any related diagnostic testing required for employment, licensing, insurance, adoption, school, camp or sports participation when services will result in duplication of Plan benefits for routine preventive care. Immunizations for the purpose of obtaining or maintaining employment are also excluded.
27. Chiropractic treatment except as provided under this Plan as set forth in this Summary Plan Description under *Supplemental Benefits*.
28. Outpatient prescription drugs, unless provided under this Plan as set forth in this Summary Plan Description under *Supplemental Benefits*; other drugs or medications except when provided to the Member in an inpatient setting.
28. Eye refractions, eyeglasses, contact lenses, hearing aids, augmentative communication devices (unless medically necessary) or audiometric exams unless the Company has selected this coverage as evidenced by inclusion in the *Medical Benefits Summary* section of this document.
29. Surgical treatment and associated care for treatment of obesity and any complication resulting from the treatment. Or when it is covered - Surgical treatment and associated care for treatment of obesity, except when it is determined that the patient meets UnitedHealthcare's established criteria for such treatment and UnitedHealthcare determines such treatment to be medically necessary.
30. Any fees relating to any types of services or items resulting from an injury sustained as a result of the Member's commission of, or attempt to commit a felony. Upon Member's conviction, UnitedHealthcare will be entitled to reimbursement of any claims paid as a result of such injury.
31. Performance of an injection by a nurse or physician which would normally be self-administered, except in an inpatient setting.
32. Organ and tissue transplant services as described in the section entitled *Organ Transplants* only available when the Member is the recipient of an organ or tissue transplant. Coverage as described in said section may be available for a primary live donor only when the organ or tissue recipient is a Member covered under this Plan.
33. Telephone or E-mail consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for copying medical records.
34. Charges for non-used medications.
35. Replacement of items that are lost, stolen, misused, otherwise abused, or damaged due to neglect or accident
36. Services provided to a Member as part of a demonstration project conducted or sponsored by the Centers for Medicare & Medicaid Services (CMS).

IMPORTANT COVERAGE RESTRICTIONS

Medical Necessity

Benefits will be paid only for hospital, medical or other service or treatment that is medically necessary. To be medically necessary, services must meet the following criteria as determined by UnitedHealthcare:

1. The services or treatment are consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Member's medical condition; and,
2. The services or treatment are performed in the most cost-effective manner in terms of treatment, method, setting, frequency and intensity, taking into consideration the Member's medical condition.

Inability to Provide Services

In the event of any major disaster or epidemic, war, riot or labor dispute, UnitedHealthcare will use its best judgment to provide hospital and medical services under this Plan, as far as is practical, with whatever facilities and personnel are available during the crisis. In this situation UnitedHealthcare will not be held liable for delay or failure to provide, or arrange for, hospital or medical services due to the lack of available facilities or personnel.

Relationship Between the Parties

Any organization with whom UnitedHealthcare has a contract is an independent contractor. No employee or agent of an organization with whom UnitedHealthcare contracts is an employee or agent of UnitedHealthcare. No UnitedHealthcare employees or agents are considered to be employees or agents of any organization with whom UnitedHealthcare contracts.

Discretionary Authority of UnitedHealthcare

UnitedHealthcare has discretionary authority to determine eligibility for benefits and to construe and interpret all terms and provisions of this document. UnitedHealthcare may delegate its discretionary authority to another person, partnership, corporation or other legal entity.

COORDINATION OF BENEFITS

The medical benefits under this Plan will be coordinated with the medical benefits of any other group medical plan under which you or one of your Eligible Dependents is covered, to prevent duplication of payments.

The maximum the Plan pays for medical benefits is the difference between the benefits paid by the other plan and the benefits that would have been paid under this Plan. Your expenses are covered first by the Plan--your primary coverage. Your spouse's expenses are covered first by his or her plan--their primary coverage. The primary plan pays benefits first without regard to benefits that may be payable under the secondary plan.

Here is an example of how this might work in a hypothetical situation:

John is a Community Schools' employee covered under this Plan, with benefits for hospital services payable at 100% after a \$100 Deductible. Mary, his wife, works for ABC Corp., and is covered under another plan with hospital benefits payable at 80% after a \$50 Deductible.

\$1000		Amount of Allowed Charge for hospital services
<u>50</u>		Minus Mary's Deductible
950		Billed to Mary's Plan
<u>760</u>		Minus 80% of \$950 paid by Mary's plan
190		Balance due to be coordinated with John's Plan
<u>140*</u>		Amount paid by John's Plan.
50		Balance due

*This figure is calculated by first figuring what the Plan would have paid, had there been no coordination of benefits, minus what Mary's plan paid after her Deductible. (\$900 minus \$760 equals \$140)

Responsibility for order of payment is determined on a primary or secondary plan basis and works like this:

1. If the other group plan has no coordination of benefit provision, it automatically is the primary plan.
2. If the other group plan has a coordination of benefits provision, then the following will apply in determining whether this Plan or the other group plan is primary:
 - a. The plan covering the patient as an employee or as other than a dependent will be the primary plan.
 - b. The "birthday rule" is used to determine the order of benefit determination for dependent children in a non-separation/divorce situation. Under the birthday rule, the parent whose birthday falls earlier in the year (month and day) has primary insurance responsibility.

For example, John Smith's birthday is August 13. His wife, Mary, has a birth date of May 18. Mary Smith's plan would be primary for any dependent children in the family.

- c. In a separation or divorce situation, the order of benefit determination would be made in the following manner:
 - 1) If the parent with custody of the child has not remarried, the plan of the parent with custody will be the primary plan.
 - 2) If the parent with custody has remarried:
 - a) The plan of the custodial parent will be primary.
 - b) The plan of the stepparent, secondary.

c) The plan of the parent without custody will be third.

NOTE: Where a court order specifying the responsibility for medical costs is issued, the court order will determine which plan will be the primary plan.

Where a determination cannot be made in accordance with the above, the plan which has covered the patient for the longer period of time will be the primary plan.

THIRD PARTY LIABILITY

If You or an Eligible Dependent are involved in an accident where there may be a legal claim against a liable third party, the Plan may pay for expenses which may be the responsibility of that third party. When that happens, the Plan has the right to recover benefits paid from the claim settlement, award or judgment. You or Your Eligible Dependent(s) have the following responsibilities:

1. To fully cooperate with the Plan in obtaining information about the loss and its cause.
2. To notify the Plan of any claim for damages made or lawsuit filed in connection with the loss.
3. To include the amount of the benefits paid by the Plan on behalf of You or an Eligible Dependent in claims for damages against other parties.
4. To notify the Plan of a proposed settlement at least 30 days before any claim or lawsuit is settled in regard to the loss.
5. To provide the Plan with a lien to the extent of the cash value of paid Plan benefits. This lien may be filed with the third party whose act caused the injuries, the third party's agent or court having jurisdiction in the matter.
6. To reimburse the Plan for any damages collected for benefits paid under the Plan immediately upon collection of damages by whatever means.
7. To pay the Plan all costs and expenses, including attorney's fees, which were incurred or expended by the Plan in obtaining or attempting to obtain payment from You if You fail or refuse to reimburse the Plan pursuant to this provision.
8. To permit the Plan to file a lawsuit in the name of You or Your Eligible Dependent against the person whose act caused the injuries.

The Plan shall be reimbursed first from any judgment, payment or settlement regardless of whether You or Your Eligible Dependent is fully compensated. If any amount remains, it will be given to You or Your Eligible Dependent.

COMPLAINT, APPEAL AND DISPUTE RESOLUTION PROCEDURES

The following procedures provide a formal system for resolving Complaints or Appeals concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare.

Most Complaints can be resolved on an informal basis by consultation between You, UnitedHealthcare staff, and/or the health practitioner from whom You received services. If Your Complaint cannot be resolved after informal consultation, You or Your Authorized Representative may request a formal Appeal. If You want to designate an Authorized Representative to assist You with this Appeals Process, this must be done in writing. Your Authorized Representative may not file a formal Appeal without explicit, written designation by You.

You must exhaust the Appeals Process prior to pursuing additional dispute resolution remedies.

EXPEDITED APPEAL PROCEDURE FOR URGENT CARE CLAIMS

For Urgent Care Claims, You or Your Authorized Representative may contact UnitedHealthcare, orally or in writing, to request expedited consideration of a formal Appeal. In determining whether a claim is for urgent care, UnitedHealthcare will apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. If the request for expedited consideration is denied, the Appeal will automatically be reviewed according to the procedures described in the section entitled, *Appeal Procedure for Pre-Service and Post-Service Claims That Are Not Urgent Care Claims*. A request for expedited consideration will not be denied if a Physician with knowledge of Your medical condition determines that Your claim involves urgent care.

UnitedHealthcare will submit Your expedited appeal to an independent Physician reviewer. The independent Physician reviewer will be a Clinical Peer, who has no material, professional, familial or financial affiliation with UnitedHealthcare or You, or material, familial or financial connection to the case and/or outcome.

Within 72 hours after UnitedHealthcare receives a request for expedited handling which includes all necessary information, UnitedHealthcare will issue a decision based on the independent Physician reviewer's final determination to You or Your Authorized Representative by telephone or facsimile. Written confirmation of UnitedHealthcare's final decision will be mailed to You or Your Authorized Representative within three calendar days after UnitedHealthcare provides the final decision by telephone or facsimile. If additional information is needed, You or Your Authorized Representative will be notified within 24 hours of the expedited Appeal request specifying what information is needed to make a decision. When the additional information is received, a final decision will be made within 48 hours of receipt of the specified information or at the end of the period given to provide the specified information, whichever is earlier.

If UnitedHealthcare's final decision is adverse to You, You or Your Authorized Representative may request binding arbitration as described under the section entitled, *Arbitration Procedure*, or bring a civil action as described in the section entitled, *Civil Actions Available Under ERISA*.

APPEAL PROCEDURE FOR PRE-SERVICE AND POST-SERVICE CLAIMS THAT ARE NOT URGENT CARE CLAIMS

For Pre-Service and Post-Service Claims that are not Urgent Care Claims, You or Your Authorized Representative may request an Appeal by completing a written "Member Appeal Form," which will be provided to You or Your Authorized Representative upon written or oral request. The Member Appeal Form must be completed and filed to UnitedHealthcare within 180 calendar days from the date: (1) the Member received notification of a denial of coverage; or (2) the problem in question occurred. The Member Appeal Form must be completed and signed and the facts as alleged shall be binding on the Member. The Member Appeal Form must be filed by mail, facsimile, or hand-delivery to UnitedHealthcare, according to the instructions provided with the Member Appeal Form.

UnitedHealthcare will issue a final decision, in writing, to You or Your Authorized Representative within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the Member Appeal Form.
- Post-Service Claim: 30 calendar days after receipt of the Member Appeal Form.

If UnitedHealthcare's decision on the Appeal is adverse to You, You have the right to further review. For Appeals related to determinations which require medical judgment, including determinations of medical necessity, You or Your Authorized Representative may request an Independent Physician Review (IPR) as described under the subsection entitled, *Independent Physician Review Procedure*. For all other Appeals, You or Your Authorized Representative may request a reconsideration of the Appeal decision as described under the subsection entitled, *Member Reconsideration Procedure*.

Independent Physician Review Procedure

You or Your Authorized Representative may request an "Independent Physician Review" (IPR) of an adverse decision resulting from an Appeal which denied You coverage on the basis that the service, procedure, or treatment in question was not medically necessary or medically appropriate. The provisions in this section shall not be construed to obligate UnitedHealthcare to make payment for any health care service, procedure, or treatment which is not covered under Your Plan.

At the time You or Your Authorized Representative is notified of the adverse Appeal decision described above, You shall also be advised of Your right to request an IPR. You or Your Authorized Representative must request an IPR within 30 calendar days of receiving UnitedHealthcare's adverse Appeal decision.

The independent Physician reviewer will be a Clinical Peer, who has no material, professional, familial or financial affiliation with UnitedHealthcare or You, or material, familial or financial connection to the case and/or its outcome. UnitedHealthcare will not charge You any fees for an IPR filing or case review, or fees associated with diagnostic tests or other clinical services the External Independent Review Organization (EIRO) requests in order to complete the review. However, UnitedHealthcare is not responsible for other costs such as those associated with You retaining an attorney.

After receiving a request for IPR, UnitedHealthcare will provide the following information to the EIRO:

- all relevant medical records and appropriate portions of the Appeal file;
- supporting documentation used to render the decision pertaining to Your case;
- a summary description of the applicable issues, including a statement of UnitedHealthcare's decision;
- the relevant portions of UnitedHealthcare's utilization management criteria, if applicable;
- any additional information or comments submitted by You or Your Authorized Representative to UnitedHealthcare regarding the Appeal; and
- any new information related to Your case that has become available since the initial Appeal decision.

UnitedHealthcare will issue a final written decision, based on the independent Physician reviewer's final determination, to You or Your Authorized Representative within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the request for IPR.
- Post-Service Claim: 30 calendar days after receipt of the request for IPR.

If UnitedHealthcare's final decision is adverse to You, You or Your Authorized Representative may request binding arbitration as described under the section entitled, *Arbitration Procedure*, or bring a civil action as described in the section entitled, *Civil Actions Available Under ERISA*.

Member Reconsideration Procedure

A reconsideration of an adverse Appeal decision is available for any Pre-Service or Post-Service Claim which does not require a determination of medical necessity, or which does not require medical judgment. You have 30 calendar days from the date the Appeal decision was issued in which to file a request for reconsideration to the Member Reconsideration Committee of UnitedHealthcare.

The Committee meeting shall be held at the UnitedHealthcare home office in Moline, Illinois. You or Your Authorized Representative will be notified that the Member Reconsideration Procedure Committee will meet to hear Your case, and

You or Your Authorized Representative will be provided the opportunity to submit additional information or comments in writing. The Reconsideration Committee shall resolve the Appeal by majority vote and will issue a final decision to You or Your Authorized Representative within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the request for reconsideration.
- Post-Service Claim: 30 calendar days after receipt of the request for reconsideration.

If UnitedHealthcare's decision on the reconsideration is adverse to You, You or Your Authorized Representative may request binding arbitration as described under the section entitled, *Arbitration Procedure*, or bring a civil action as described in the section entitled, *Civil Actions Available Under ERISA*.

CIVIL ACTIONS AVAILABLE UNDER ERISA

If You remain dissatisfied after exhausting either:

- 1) the Expedited Appeal Procedure for Urgent Care Claims; or
- 2) the Appeal Procedure for Pre-Service and Post-Service Claims that are not Urgent Care Claims, and either
 - a) the Independent Physician Review Procedure, or
 - b) the Reconsideration Procedure, whichever is applicable,

then You have a right to bring a civil action under section 502(a) of ERISA, or to pursue arbitration as described under the section entitled, *Arbitration Procedure*.

ARBITRATION PROCEDURE

Arbitration shall be conducted in accordance with the then current Employee Benefit Plans Claims Arbitration Rules of the American Arbitration Association (AAA). A request for arbitration must be filed with UnitedHealthcare and the American Arbitration Association in writing within six months of the date of the final Appeal decision being arbitrated. The question for the arbitrator will be whether the decision of UnitedHealthcare should be set aside because the decision was arbitrary and capricious. Judgment upon the decision by the arbitrator may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. The expenses associated with the arbitration will be shared equally by both parties. Arbitration is final and binding on the parties. The parties waive their right to remedies in court, including their right to jury trial, except for the enforcement of the decision of the arbitrator. The Member and UnitedHealthcare agree that the arbitrator shall have no authority to award punitive damages and waive their right to such damages.

RESOLUTION OF UNRESOLVED DISPUTES NOT RELATING TO URGENT CARE, PRE-SERVICE, OR POST-SERVICE CLAIMS

All unresolved disputes which do not relate to Urgent Care Claims, Pre-Service Claims, or Post-Service Claims shall be resolved through mandatory, binding arbitration as described above.

Upon written request and free of charge, You or Your Authorized Representative may request copies of all documents relevant to Your Appeal and either the independent Physician review or reconsideration.

UNITEDHEALTHCARE SERVICES COMPANY OF THE RIVER VALLEY, INC. OFFICES

UnitedHealthcare Services Company of the River Valley, Inc.
1300 River Drive, Suite 200
Moline, Illinois 61265
(800) 747-1446

UnitedHealthcare Services Company of the River Valley, Inc.
2033 Meadowview Lane, Suite 300
Kingsport, Tennessee 37660
(800) 224-6602

UnitedHealthcare Services Company of the River Valley, Inc.
408 North Cedar Bluff Road, Suite 400
Knoxville, Tennessee 37923
(800) 224-6602

UnitedHealthcare Services Company of the River Valley, Inc.
7210 North Villa Lake Drive
Peoria, Illinois 61614
(800) 747-1446

UnitedHealthcare Services Company of the River Valley, Inc.
P. O. Box 9000
Waterloo, Iowa 50704
(800) 747-1446

UnitedHealthcare Services Company of the River Valley, Inc.
11141 Aurora Avenue
Urbandale, Iowa 50322

ERISA INFORMATION

Classification:

This is a welfare benefit plan providing comprehensive medical benefits.

Plan Number:

Employer Identification Number:

Record keeping Period:

Plan Administrator/Plan Trustee:

Contact's Name/Position
ABC Company
Address
Phone Number

Agent for service of Legal Process:

Fiduciary for Appeals:

Payment of benefits is made through:
UnitedHealthcare Services Company of the River Valley, Inc.
3800 – Avenue of the Cities, Suite 200
Moline, IL 61265

Funding of Plan:

Self-funded by ABC Company. UnitedHealthcare Services Company of the River Valley, Inc. does not insure Your employer or You.

Premium Disclosures:

For More Information:

Questions about Your benefits can be addressed to Your Human Resources Department.

Statement of ERISA Rights

As a participant in this Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Members shall be entitled to:

Receive Information About Your Plan and Benefits

You can examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including health benefit contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Company with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

You can obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including health benefits contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

You can receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to 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.

You are entitled to reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Members, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Members and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the material and pay You *up to \$110 a day* until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. ***In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.*** If it should happen that Plan fiduciaries misuse the Plan's

money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory of the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

MEMBER RIGHTS AND RESPONSIBILITIES

Member has the right to:

1. Be treated with respect and dignity by UnitedHealthcare personnel and Network Physicians and Providers.
2. Privacy and confidentiality for treatments, tests or procedures You receive.
3. Voice concerns about the service and care You receive.
4. To register complaints and Appeals concerning Your health plan or the care provided to You.
5. Receive timely responses to Your concerns.
6. Participate in a candid discussion with Your Physician about appropriate and medically necessary treatment options for Your conditions, regardless of cost or benefit coverage.
7. Be provided with access to health care, Physicians and other health care professionals.
8. Participate with Your Physician and other caregivers in decisions about Your care.
9. Make recommendations regarding the organization's Member's Right and Responsibilities policies.
10. Receive information about UnitedHealthcare, our services and Network Physicians and other health care professionals.
11. Be informed of, and refuse to participate in, any experimental treatment,.
12. Have coverage decisions and claims processed according to regulatory standards.
13. Choose an Advance Directive to designate the kind of care You wish to receive should You be unable to express Your wishes.

Member has the responsibility to:

1. Know and confirm Your benefits before receiving treatment.
2. Contact an appropriate health care professional when You have a medical need or concern.
3. Show Your ID card before receiving healthcare services.
4. Pay any necessary Copayment at the time You receive treatment.
5. Use Emergency Room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
6. Keep scheduled appointments.
7. Provide information needed for Your care.
8. Follow agreed-upon instructions and guidelines of Physicians and healthcare professionals.
9. Participate in understanding Your health problems and developing mutually agreed upon treatment goals.
10. Notify Your employer's Human Resource Department of changes in address or family status.
11. Visit our website www.UHCRiverValley.com or call customer service when You have a question about Your eligibility, benefits, claims and more.
12. Access our website www.UHCRiverValley.com or call customer service to verify that Your Physician or health care professional is participating in the UnitedHealthcare Services Company of the River Valley, Inc. network before receiving services.

ADVANCE MEDICAL DIRECTIVES

UnitedHealthcare has been instructed by federal law to inform you about your rights under The Patient Self-Determination Act.

What happens if you become too sick to make your own decisions regarding your medical care? Your family and doctor must decide what treatment to use, when not to treat, and when to stop treatment. Sometimes they don't know what you would want, or aren't able to agree on what would be best for you. It is much better if they are sure of what you want and who you want to make these decisions.

With the enactment of a federal law, The Patient Self-Determination Act, you have the right to make decisions about your future health care. This includes the right to accept or refuse medical or surgical treatment and to plan and direct the types of health care you may receive if you become unable to express your wishes.

You can exercise this right by making an Advance Medical Directive.

UnitedHealthcare supports your rights under this law. However, coverage of your medical care by UnitedHealthcare is in no way influenced by your having an Advance Medical Directive.

UnitedHealthcare's providers have, in accordance with state law, varying practices regarding the implementation of an advance directive. Such practices must be made available to you when selecting or receiving care from the provider.

For example, if your Physician, as a matter of conscience, is unable to comply with your directives, they must take all reasonable steps to arrange to transfer you to another Physician.

What is an Advance Directive?

An advance directive explains, in writing, your choices about the treatment you want or do not want, or about how health care decisions will be made for you if you are too ill to express your wishes.

An advance directive expresses your personal wishes and is based upon your beliefs and values. When you make an advance directive, you will consider issues like dying, living as long as possible, being kept alive on machines, being independent, and the quality of your life.

Use of an Advance Medical Directive makes it possible for your wishes to be carried out during a serious illness.

If you are an adult and of "sound mind," you can make an advance directive. There are two types of formal advance directives. You can complete a Living Will, a Power of Attorney for Health Care, or both.

Living Will

A Living Will informs your Physician that you want to die naturally if you develop an illness or injury that cannot be cured. It tells your Physician that, when you are near death or in a vegetative state, he or she should not use life-prolonging measures that postpone, but do not prevent, death.

A Living Will allows you to refuse treatments or machines which keep your heart, lungs or kidneys functioning when they are unable to function on their own.

The Power of Attorney for Health Care

The Power of Attorney for Health Care is a form in which you appoint another person (a "health care agent") to make health care decisions for you if you are not capable of making them yourself.

Maintaining Your Advance Directive

You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a safe deposit box.) You should make sure your family members and your lawyer, if you have one, know you have made an advance directive and know where it is located.

Be sure your Plan Physician has a copy of your directive in your medical file.

Most states have specific rules as to what will be recognized as a valid advance directive. Forms are available through your state's Medical Society or Bar Association. Follow the instructions provided by your state when completing the advance directives forms.

Will All States Recognize My Directives?

If you plan to spend time in a state other than your state of residence, from which you obtained your Advance Medical Directives, you may wish to execute advance directives in compliance with that state's laws as well.

Specific questions should be directed to your Physician and/or attorney.

NMHPA

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

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

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

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