UnitedHealthcare

Summary Plan Description

High Deductible Health Plan (HDHP)

for the State Health Benefit Plan (SHBP)







Effective: January 1, 2022
Group Number: 902786

Table of Contents UnitedHealthcare HDHP Summary Plan Document

UnitedHealthcare- Medical Claims Administrator

SECTION 1 – WELCOME 5

- To Report Fraud and Abuse
- Information about Defined Terms
- Medical Claims submitted address
- Membership Correspondence for issues related to Medical Claim Appeals
- Membership Correspondence and Appeals for Eligibility Issues (other than medical or pharmacy claims)
- For issues related to the Well-Being Incentive Appeal Process
- CVS Caremark Customer Care
- SHBP Contact/Resources Information

SECTION 2 - HOW THE PLAN WORKS 8

- Well-Being Program, Administered by Sharecare
- Using the Health Incentive Account (HIA) in the High Deductible Health Plan (HDHP)
- Health Services from Non-Network Providers Paid as Network Benefits
- Network Providers
- Transition of Care
- Eligible Expenses
- Limitations on Selection of Providers
- Annual Deductible
- Co-insurance
- Out-of-Pocket Maximum
- How This HDHP Option Works
- Your Health Savings Account (HSA) Opportunity

SECTION 3 - PERSONAL HEALTH SUPPORT and PRIOR AUTHORIZATION 16

- Care Management
- Prior Authorization Requirements

SECTION 4 – SCHEDULE OF BENEFITS 19

SECTION 5 - ADDITIONAL COVERAGE DETAILS 27

- Applied Behavior Analysis (ABA) Services for Autism Spectrum Disorders (ASD)
- Ambulance Services
- Cancer Resource Services (CRS)
- Cellular and Gene Therapy
- Clinical Trials – Routine Patient Care Costs
- Congenital Heart Disease (CHD) Surgeries
- Dental Services - Accident Only and Oral Care Surgery
- Diabetes Services
- Durable Medical Equipment (DME)
- Emergency Health Services
- Hearing and Hearing Aids
- Home Health Care
- Hospice Care
- Hospital - Inpatient Stay
- Infertility Services
- Kidney Resource Services (KRS)
- Lab, X-Ray and Diagnostics – Outpatient
- Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient

- Mental Health Services
- Nutritional Counseling
- Obesity Surgery
- Ostomy Supplies and Urinary Catheter Supplies
- Pharmaceutical Products – Outpatient
- Physician Fees for Surgical and Medical Services
- Physician's Office Services - Sickness and Injury
- Pregnancy - Maternity Services
- Preventive Care Services
- Prosthetic Devices
- Reconstructive Procedures
- Rehabilitation Services - Outpatient Therapy and Manipulative Treatment
- Scopic Procedures - Outpatient Diagnostic and Therapeutic
- Skilled Nursing Facility/ Rehabilitation Facility Services
- Substance- Related and Addictive Disorder Services
- Surgery – Outpatient
- Temporomandibular Joint (TMJ) Services
- Therapeutic Treatments – Outpatient
- Transplantation Services
- Travel and Lodging
- Urgent Care Center Services
- Virtual Visits
- Vision Examinations
- Wigs

SECTION 6 – CLINICAL PROGRAMS AND RESOURCES 49

- NurseLine℠
- Disease and Condition Management Services
- Wellness Management Services
- Tobacco Surcharge

SECTION 7 - EXCLUSIONS: WHAT THE PLAN WILL NOT COVER 54

- Alternative Treatments
- Dental
- Devices, Appliances and Prosthetics
- Drugs
- Experimental or Investigational or Unproven Services
- Foot Care
- Medical Supplies and Equipment
- Mental Health and Substance- Related and Addictive Disorder Services
- Nutrition
- Personal Care, Comfort or Convenience
- Physical Appearance
- Procedures and Treatments
- Providers
- Reproduction
- Services Provided under Another Plan
- Transplants
- Travel

- Types of Care
- Vision and Hearing
- All Other Exclusions

SECTION 8 – CLAIMS PROCEDURES 63

- Network Benefits
- Non-Network Benefits
- Filing a Claims for Benefits
- If Your Provider Does Not File Your Claim
- Payment of Benefits
- Health Statements
- Explanation of Benefits (EOB)
- Claim Denials and Appeals
- To Resolve a Question or Appeal
- Federal External Review Program
- Limitation of Action

SECTION 9 - COORDINATION OF BENEFITS (COB) 71

SECTION 10 - SUBROGATION AND REIMBURSEMENT 75

SECTION 11 – GLOSSARY 76

SECTION 12 - IMPORTANT ADMINISTRATIVE INFORMATION 88

NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS 90

GETTING HELP IN OTHER LANGUAGES OR FORMATS 90

WELLNESS PROGRAM ADMINISTRATOR 96

- The Well-Being Program – *Be Well SHBP*®
- Sharecare Well-Being Services
- Tobacco Surcharge Policies and Cessation
- 2022 Well-Being Incentive Appeal Process
- Sharecare Definitions

PHARMACY BENEFITS ADMINISTRATOR – OUTPATIENT PRESCRIPTION DRUG RIDER 105

- Outpatient Prescription Drug Rider
- What Is Covered - Prescription Drug Benefits
- Pharmacy Type and Supply Limits
- What Is Not Covered – Prescription Drug Exclusions
- Frequently Asked Questions- Prescription Drug
- Prescription Drug Glossary and Definitions

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES 122

SECTION 1 - WELCOME

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

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

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

This booklet is notice to all Covered Persons of the Plan's benefits payable under the Choice HDHP Option for services provided on or after January 1, 2022, unless otherwise noted. Any and all statements to Covered Persons or to providers about payment or levels of payment that were made before January 1, 2022 are canceled if they conflict in any way with the provisions described in this booklet.

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

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

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

For more information about your Pharmacy Benefits see the "Outpatient Prescription Drug Rider" Section of this SPD or go to your Pharmacy Benefits Administrator's website, info.caremark.com/shbp. For more information about your Wellness Benefits, see the "Well- Being Program" in the Sharecare Section of this SPD or go to the Wellness Program Administrators website, www.BeWellSHBP.com. These benefits are not administered by UnitedHealthcare.

Fraud and Abuse

Please notify UnitedHealthcare of any fraudulent activity regarding Covered Persons, providers, payment of benefits, or other reasons by calling Member Services at (888) 364-6352.

Information about Defined Terms

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

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

To Use This SPD

- Read the entire SPD and share it with your family. Then keep it in a safe place for future reference. If you have questions, contact UnitedHealthcare at (888) 364-6352. You should call UnitedHealthcare if you have questions about the limits of the coverage available to you.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- Find copies of your SPD and any future amendments at www.shbp.georgia.gov or by contacting UnitedHealthcare Member Services at (888) 364-6352.
- Capitalized words in the SPD have special meanings and are defined in Section 11, *Glossary*. If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 11, *Glossary*.
- Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Medical Claims submittal address

UnitedHealthcare – Claims
P.O. Box 740809
Atlanta, GA 30374-0800

Membership Correspondence for issues related to Medical Claim Appeals

Please see Section 8, *Claims Procedures, Claim Denials and Appeals* on how to appeal an adverse determination. Requests for Review of Denied Claims/Appeals and Notice of Complaints:

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

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

Membership Correspondence and Appeals for Eligibility Issues (other than medical or pharmacy claims):

State Health Benefit Plan
Attention: Eligibility Appeals
P.O. Box 1990
Atlanta, GA 30301

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

For issues related to the Well-Being Incentive Appeal Process:

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

CVS Caremark Customer Care

Prescription drug pharmacy benefits are administered separately by the Pharmacy Benefits Administrator, CVS Caremark. Please see the "Outpatient Prescription Drug Rider" in this SPD. Prescription drug written appeals and inquiries should be directed to:

CVS Caremark/SHBP
Appeals Department MC 109
P.O. Box 52071
Phoenix, AZ 85072-2071

STATE HEALTH BENEFIT PLAN (SHBP) CONTACT / RESOURCES INFORMATION		
	Member	**Website**
Medical Claims Administrator – United Healthcare Services, Inc. Member Service Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday Mental Health & Substance – Related Addictive Disorder Services Hours: 8:00 a.m. – 6:00 p.m. ET Monday – Friday NurseLine℠: 24 hours a day / 7 days a week Report Suspected Fraud and Abuse	(888) 364-6352 TDD (800) 255-0056 (888) 364-6352 TDD (800) 255-0056 (888) 364-6352 (888) 364-6352	www.myuhc.com
Wellness Program Administrator- Sharecare Member Service Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday Corporate Compliance	(888) 616-6411 (844) 401-0005	www.BeWellSHBP.com
Pharmacy Benefits Administrator- CVS Caremark Customer Care Hours: 24 hours a day / 7 days a week Fraud Tip Hotline	(844) 345-3241 (877) CVS-2040	info.caremark.com/shbp
SHBP Member Services Hours: 8:30 a.m. – 5:00 p.m. ET Monday – Friday	(800) 610-1863	www.mySHBPga.adp.com
Additional Information		
Centers for Medicare & Medicaid (CMS) 24 hours a day / 7 days a week	(800) 633-4227 TTY (877) 486-2048	www.medicare.gov

SECTION 2 - HOW THE PLAN WORKS

This section includes:

- Well-Being Program; Administered by Sharecare
- Accessing Network Benefits;
- Eligible Expenses;
- Annual Deductible (Separate Network Deductible and Out-of-Network Deductible);
- Co-insurance;
- Out-of-Pocket Maximum. (Separate Network Out-of-Pocket Maximum and non-Network Out-of-Pocket Maximum);
- Your Health Savings Account (HSA) Opportunity

The purpose of this High Deductible Health Plan option is to pay costs of most medically necessary care and treatment of illness and accidental Injury for Covered Persons after a high Deductible has been satisfied. This Plan Option offers Network and non-Network providers. You must meet separate Network and non-Network Deductibles and Out-of-Pocket Maximums. Medical claims properly coded as Preventive Care and received from a Network provider are not subject to the Deductible and paid at 100%.

Well-Being Program, Administered by Sharecare

After you complete health actions from the Well-Being Program, *Be Well SHBP*®, administered by Sharecare, you earn points. To redeem 2022 points for well-being incentive credits you must redeem your points through Sharecare's Redemption Center as these will not be sent automatically to UnitedHealthcare. You may do so in increments of 120 up to a maximum of 480. Credits will be available within 30 days of redemption and will be deposited into your Health Incentive Account (HIA). You may also redeem your 2022 points for a $150 Sharecare Rewards Visa® Prepaid Card. See the Sharecare section of this SPD for details.

***Special UnitedHealthcare note*:** Additionally, UnitedHealthcare will match up to an additional 240 well-being incentive credits into your HIA when the member and covered spouse complete all 2022 required Sharecare program activities and manually redeem their points in the Sharecare Redemption Center.

Rollover Credits

Unused well-being incentive credits earned in 2021 will automatically roll over to your 2022 Plan Option. Unused credits will be deposited in your HIA for the HDHP in April 2022.

Using the Health Incentive Account (HIA) for the HDHP

IMPORTANT: Before well-being incentive credits available in the HIA can be used with the HDHP, you will need to pay for Covered Health Services until the following amounts have been paid toward your Deductible (**Note:** This does not encompass your entire Deductible).

- You - $1,400
- You + Child(ren) - $2,800
- You + Spouse - $2,800
- You + Family - $2,800

After you pay the above portion amount of your Deductible and you have already redeemed for well-being incentive credits, we will automatically use available well-being incentive credits, at the time a claim is received, from your HIA to help offset eligible medical and pharmacy expenses.

You can continue to save money in a Health Savings Account (HSA) for services that the HIA may not pay for. Remember, your HSA can be used to save for expenses you will have in the future. Please note that the credits you earn in your HIA are separate and apart from the dollars in your HSA.

Using the HIA for outpatient prescription drugs filled at a Pharmacy:

As pharmacy benefits are administered separately by the Pharmacy Benefits Administrator, CVS Caremark, you will need to pay out-of- pocket for your prescriptions.

NOTE: If you have available well-being incentive credits in your HIA at the time a claim is received, the credits will be applied to eligible medical and pharmacy claims. UnitedHealthcare will automatically mail you a reimbursement check (up to amount of HIA credits available). Well-being incentive credits cannot be applied to claims retroactively.

Accessing Network Benefits

As a member in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply. You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, non-Network Benefits may also be referred to as Out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 11, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your UnitedHealthcare Member ID card every time you request health care services from a Network provider. If you do not show your Member ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

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

Note: Non-Covered Health Services are not eligible for reimbursement, regardless if the provider is Network or non-Network.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time,

www.myuhc.com has the most current source of Network information.

Emergency Health Services are always paid as Network Benefits. Emergency Health Services provided by non-Network providers will be covered at Network level of Benefits.

Network Providers
UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. Or you might find that a particular Network provider may not be accepting new patients. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your UnitedHealthcare Member ID card or log onto www.myuhc.com. Before obtaining services you should always verify the Network status of a provider. You must choose a Network provider to receive Network Benefits.

Network providers are not UnitedHealthcare agents or employees, nor are they agents or employees of UnitedHealthcare. The relationships between UnitedHealthcare and Network providers are solely contractual relationships. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the telephone number on your Member ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your UnitedHealthcare Member ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare for assistance.

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

Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are negotiated by UnitedHealthcare or an amount permitted by law.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the non-Network provider and UnitedHealthcare.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and

non-Ancillary Services for unforeseen or urgent medical needs that arise at the time of service, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the non-Network provider and UnitedHealthcare.
  - The amount determined by *Independent Dispute Resolution (IDR)*.
  -

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the non-Network provider and UnitedHealthcare.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an non-Network provider may not bill you, for amounts in excess of your Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- When Covered **Health** Services are received from a non-Network provider, except as described above, Eligible Expenses are determined, based on one of the following:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
  - ♦ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar freestanding laboratory service.
    - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
  - ♦ When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). *UnitedHealthcare* and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to *UnitedHealthcare's* website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not

apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.

- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Service Act*.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services. You may appeal this decision to UnitedHealthcare. If you don't make a selection within 31 days of the date we notify you, UnitedHealthcare will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Out-of-Network Benefits.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including covered outpatient prescription drugs provided in a separate prescription drug plan administered by CVS Caremark.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Co-insurance

Co-insurance is the amount you pay each time you receive certain Covered Health Services. Please review the complete definition of Co-insurance in Section 11, *Glossary*. Co-insurance amounts are listed on the following pages next to the description for each Covered Health Service (see Section 4, *Schedule of Benefits*). Co-insurance is a percentage of the cost of Eligible Expenses.

Co-insurance – Example

Assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 70% after you meet the Network Annual Deductible, you are responsible for paying the other 30%. This 30% is your Network Co-insurance.

Out-of-Pocket Maximum

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

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

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums.

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Co-insurance Payments, even those for covered outpatient prescription drugs provided in a separate prescription drug plan administered by CVS Caremark	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	No	No

How This HDHP Option Works

This HDHP Option offers network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. This Plan has a low monthly premium, but you must satisfy separate in-Network and non-Network Deductibles and separate in-Network and non-Network Out-of-Pocket Maximums.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider. If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum or Deductible. You may want to ask the non-Network provider about their billed charges before you receive care. Deductibles apply to all Covered Health Services, including outpatient prescription drug expenses filled at a pharmacy (pharmacy benefits administered by CVS Caremark) before Benefits are paid. That means that you will pay the entire cost of medical treatment from Network Providers and non-Network Providers and outpatient prescription drug medications from Network Pharmacies until the Network or non-Network Deductibles are satisfied. Then you must pay the applicable Coinsurance percentage of Eligible Expenses until you meet the Network or non-Network Out-of-Pocket Maximums. Once met, the Benefits are paid at 100% of Eligible Expenses for the remainder of the calendar year.

Note: Benefits for Preventive Care Services are covered at 100% when seeing a Network Provider and you do not have to satisfy the Deductible before those Preventive Care Services are paid (see Section 5, *Additional Coverage Details, Preventive Care Services,* for definition of Preventive Care Services. There are no non-Network Benefits for Preventive Care Services. If you receive treatment from a non-Network Provider, you will have to pay the entire cost of medical treatment from the non-Network Provider until the non-Network Deductible is satisfied. This HDHP Option is designed to work with a Health Savings Account. You may start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options.

Your Health Savings Account (HSA) Opportunity

An HSA is like a personal savings account for healthcare, except with valuable tax advantages. When you enroll in the High Deductible Health Plan (HDHP), you may be eligible to open a HSA with an independent HSA administrator/custodian. You will need to contact a local bank or other financial organization to set-up your HSA Account.

Your HSA is yours and is not provided by the SHBP, the Plan Administrator or UnitedHealthcare. We do not sponsor or establish your HSA. You may open a HSA if you enroll in the HDHP and do not have other coverage through your spouse's employer's plan, Medicare, Medicaid, a full unrestricted Health Care Savings Account (HCSA) – or any other medical plan.

The following table gives more information about an HSA:

HSA Highlights	
What you can contribute to an HSA in 2022 as long as you continue to be enrolled in the HDHP If you are 55 or older, you may contribute additional dollars, up to $1,000/ year, as "catch-up" contributions. If your spouse is also 55 or older, he or she may establish a separate HSA and make a "catch-up" contribution to that account	**Contribution Limits for 2022** You (Individual) Coverage $3,650 You + Child(ren) or You + Spouse $7,300
How you contribute	Through deposits you make directly to the HSA administrator you select either in a lump sum or in installments throughout the year. Payroll deductions maybe available through your employer
What you can use your HSA to pay while keeping the tax advantage	Healthcare expenses (medical, dental, vision, over-the- counter medications prescribed by physician) the IRS considers tax-deductible that are not covered by any healthcare plan, see IRS Publication 502 at www.irs.gov. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty unless an exception applies (i.e., your death, your disability, or your attainment of age 65).
How claims are paid	Varies based on HSA administrator, but generally you can pay expenses directly from your account (using a debit card or convenience checks), so there is no claim paperwork to submit
What happens at the end of the year	Unused money in your account carries forward and continues to earn interest
What happens if you don't enroll in the HDHP next year or leave your employer	You can no longer contribute to your HSA, but you keep the account. The account will continue to have a tax advantage as long as you use the balance for eligible healthcare expenses

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

This section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services that require you or your provider to obtain prior authorization from UnitedHealthcare before you receive them. In general, Network providers are responsible for obtaining prior authorization before they provide certain health services to you. You are responsible for obtaining prior authorization from United Healthcare before you receive certain health services from a non-Network provider.

Care Management

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

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

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

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

As of the publication of this SPD, the Personal Health Support program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on your UnitedHealthcare Member ID card for support.
- Inpatient care management - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your UnitedHealthcare Member ID card.

Prior Authorization Requirements

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are in Section 5, *Additional Coverage Details* within each Covered Health Service category. Failure to obtain prior authorization may result in a penalty.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare at (888) 364-6352 to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. **Network facilities and Network providers cannot bill you for services they fail to prior authorize as required.**

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. **Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.** Failure to obtain prior authorization will result in a penalty equal by 50% of the Eligible Expenses for services that are determined to be a Covered Health Service.

To obtain prior authorization from UnitedHealthcare call the number (888) 364-6352 listed on your UnitedHealthcare Member ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized, what providers are authorized to deliver the services that are subject to the authorization, as well as the place of services authorized. See Section 5, *Additional Coverage Details*, for more information.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

When you choose to receive services from non-Network providers, we urge you to confirm with UnitedHealthcare that the services you plan to receive are Covered Health Services. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore, are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other limitation or exclusion of the Plan.

Covered Persons Must Call UnitedHealthcare for Prior Authorization on the certain services to be performed by non-Network Providers. **To obtain prior authorization from UnitedHealthcare, call (888) 364-6352 listed on your UnitedHealthcare Member ID card.**

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization. If you are in doubt about whether a service is covered and requires prior authorization, please call UnitedHealthcare at (888) 364-6352. It is your responsibility to notify UnitedHealthcare of certain services and obtain prior authorization. Non-prior authorization could result in reduction in payment or non-payment. Prior authorization does not guarantee eligibility or payment. For prior authorization timeframes, and reductions in Benefits that apply if you do not obtain prior authorization, see Section 5, *Additional Coverage Details*.

For non-Network Providers, a Non-Prior Authorization penalty of 50% of Eligible Expenses will apply to Covered Out-of-Network Health Services is the Covered Person's Responsibility. For example, if billed charges are $130 and eligible expenses are $100, the Out-of-Network Benefits of 50% is $50, then this amount is reduced by 50% for member non-prior authorization penalty applies, so $25 would be the allowable amount. Non-prior authorization penalty amounts do not apply to the Out-of-Pocket Maximum.

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

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

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

Special Note Regarding Medicare

Prior authorization is required for transplant services even if Medicare is primary, and for expenses that Medicare does not cover. Call UnitedHealthcare at the number on your UnitedHealthcare Member ID whenever you need mental health and substance abuse care, even if you have primary coverage through Medicare or a health plan other than SHBP. If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from UnitedHealthcare before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 9*, Coordination of Benefits (COB).*

SECTION 4 – SCHEDULE OF BENEFITS

The table below outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Annual Deductible[1] [2]		
▪ You	$3,500	$7,000
▪ You + Child(ren) or You + Spouse	$7,000	$14,000
▪ You + Family (not to exceed the applicable Individual amount per Covered Person)	$7,000	$14,000
Note: **The Network and non-Network Deductibles are separate and are not combined.**	The Annual Deductibles apply to all Covered Health Services provided under the Plan, including Network outpatient prescription drug expenses filled at a pharmacy as described in a separate prescription drug plan administered by CVS Caremark. Once the Deductible is met depending on the provider network status, claims are paid according to plan guidelines for that individual.	
Annual Out-of-Pocket Maximum[1] [2]		
▪ You	$6,450	$12,900
▪ You + Child(ren) or You + Spouse	$12,900	$25,800
▪ You + Family (not to exceed the applicable Individual amount per Covered Person)	$12,900	$25,800
The maximum you pay for Covered Health Services, out of your pocket, in a Plan year for Co-insurance. For a complete definition of Out-of-Pocket Maximum, see Section 11, *Glossary*. **Note**: The Network and non-Network Out-of-Pocket Maximums are separate and are not combined.		

1) The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

2) The Annual Deductible and Annual Out-of-Pocket applies to all Covered Health Services under the Plan, including covered outpatient prescription drugs provided in a separate prescription drug plan administered by CVS Caremark.

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 11, *Glossary*.

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
Applied Behavior Analysis (ABA) Services for Autism Spectrum Disorders (ASD) ▪ Prior Authorization is required	70% after the Annual Deductible	
Allergy Injections, Antigens and Serum	70% after the Annual Deductible	50% after the Annual Deductible
Ambulance Services ▪ Emergency Ambulance Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	70% after the Annual Deductible	70% after the Network Annual Deductible
Cancer Resource Services (CRS)[2] ▪ Hospital Inpatient Stay	70% after the Annual Deductible	Not Covered
Cellular and Gene Therapy	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Clinical Trials - Routine Patient Care Costs Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section	
Congenital Heart Disease (CHD) Surgeries ▪ Hospital - Inpatient Stay	70% after the Annual Deductible	50% after the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Dental Services - Accident Only and Oral Care Surgery ▪ inpatient and outpatient facility ▪ oral surgery performed in Physician's office setting ▪ wisdom teeth (fully impacted only) ▪ orthognathic surgery to correct obstructive sleep apnea and for age 19 and under born with specific craniofacial syndromes, and as determined by Personal Health Support policies	70% after the Annual Deductible	50% after the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
Diabetes Self-Management Items ▪ diabetes equipment and related insulin pump supplies See Durable Medical Equipment in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See Section 5, *Additional Coverage Details*, for limits	70% after the Annual Deductible	50% after the Annual Deductible
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 2: *How the Plan Works*.	70% after the Annual Deductible	70% after the Network Annual Deductible; OR 50% after the non-Network Deductible for services that do not meet the definition of an Emergency

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Hearing Services and Hearing Aids ▪ Hearing Services- Non-Routine hearing exam not performed in an office setting ▪ Hearing aid exam and fitting	70% after the Annual Deductible	50% after the Annual Deductible
▪ Hearing aids (with a prescription or documentation of medical necessity or hearing loss). Amounts exceeding the hearing aid allowance maximum is member responsibility and does not apply to any deductible or Out-of- Pocket Maximum. See Section 5, *Additional Coverage Details*, for limits. Telephonic/online hearing tests and evaluations are not covered and are listed as exclusions under the Exclusions section of this SPD.	100% after the Annual Deductible Limited to: $1,500 hearing aid allowance every 5 years for adults, and $3,000 hearing aid allowance per hearing impaired ear every 4 years for Dependent children (0 up to age 19)	
Home Health Care	70% after the Annual Deductible	50% after the Annual Deductible
Hospice Care See Section 5, *Additional Coverage Details*, for more information. There is a Bereavement benefit maximum of 8 visits.	70% after the Annual Deductible	50% after the Annual Deductible
Hospital - Inpatient Stay	70% after the Annual Deductible	50% after the Annual Deductible
Infertility Services Limited to the diagnostic testing, but once diagnosed, treatment of infertility is not covered by the Plan. Please also refer to Section 7, *Exclusions, Reproduction.*	70% after the Annual Deductible	50% after the Annual Deductible
Kidney Resource Services (KRS) These Benefits are for Covered Health Services provided through KRS only.	70% after the Annual Deductible	50% after the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Lab, X-Ray and Diagnostics – Outpatient	70% after the Annual Deductible	50% after the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	70% after the Annual Deductible	50% after the Annual Deductible
Mental Health Services ▪ Hospital - Inpatient and Outpatient ▪ Physician's Office Services ▪ Partial Hospitalization/Intensive Outpatient Treatment; Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization Residential Treatment Centers ▪ Virtual Behavioral Health Therapy and Coaching Professional Charges inpatient limited to 1 visit per authorized day/combined/calendar year. Note: Prior Authorization is required for certain services.	70% after the Annual Deductible **Designated Network-AbleTo (see page 37)** 100% after you meet the Annual Deductible; Benefits for the Initial Consultation will be paid at 100%	50% after the Annual Deductible Not Covered
Nutritional Counseling See Section 5, *Additional Coverage Details* for benefit limits	100% after the Annual Deductible	100% after the Annual Deductible
Obesity Surgery See Section 5, *Additional Coverage Details* for limits.	70% after the Annual Deductible	Not Covered
Ostomy Supplies	70% after the Annual Deductible	50% after the Annual Deductible
Pharmaceutical Products - Outpatient (billed under the HDHP medical Plan)	70% after the Annual Deductible	50% after the Annual Deductible
Physician Fees for Medical and Medical Services	70% after the Annual Deductible	50% after the Annual Deductible
Physician's Office Services - Sickness and Injury	70% after the Annual Deductible	50% after the Annual Deductible
Pregnancy - Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section; (circumcision not done at birth subject to medical necessity)	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Preventive Care Services (that meet the requirements of Federal and State law)		
▪ Physician Office Services	100%	Not Covered
▪ Lab, X-ray or Other Preventive Tests	100%	Not Covered
▪ Immunizations (In addition to network providers Covered Persons can obtain immunizations and vaccinations at any of the Georgia Public Health Departments)	100%	Not Covered
▪ Breast Pumps	100%	Not Covered
▪ Sterilization	100% for females; OR 70% after the Annual Deductible for males	Not Covered
▪ IUD and Diaphragm (device, fitting and removal)	100%	Not Covered
Prosthetic Devices See Section 5, *Additional Coverage Details*, for limits	70% after the Annual Deductible	50% after the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Chiropractic/ Manipulative Treatment See Section 5, *Additional Coverage Details*, for more information. There is a benefit maximum of 40 visits per short therapies per Calendar Year; and for chiropractic care there is a benefit maximum of 20 visits per Calendar Year.	70% after the Annual Deductible	50% after the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after the Annual Deductible	50% after the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Skilled Nursing Facility/Rehabilitation Facility Services See Section 5, *Additional Coverage Details*, for more information. Prior Approval is required and there is a benefit maximum of 120 per Calendar Year.	70% after the Annual Deductible	Not Covered
Substance-Related and Addictive Disorder Services ▪ Hospital - Inpatient and Outpatient ▪ Physician's Office Services ▪ Partial Hospitalization/Intensive Outpatient Treatment ▪ Methadone Clinics ▪ Residential Treatment Centers Professional Charges inpatient limited to 1 visit per authorized day combined/calendar year. Note: Prior Authorization is required for certain services.	70% after the Annual Deductible	50% after the Annual Deductible
Surgery - Outpatient	70% after the Annual Deductible	50% after the Annual Deductible
Temporomandibular Joint (TMJ) Services See Section 5, *Additional Coverage Details*, for limits	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments – Outpatient	70% after the Annual Deductible	50% after the Annual Deductible
Transplantation Services (For Network Benefits, transplantation services must be received by a Designated Provider. Cornea transplants do not require to be performed by a Designated Provider in order for you to receive Network Benefits.)	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Travel and Lodging (Covered Health Services must be received by a Designated Provider.)	For patient and companion(s) of patient undergoing bariatric, cancer or transplant procedures.	Not Covered
Urgent Care Center Services	70% after the Annual Deductible	50% after the Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the number on your UnitedHealthcare Member ID card.	70% after the Annual Deductible	Not Covered
Vision Examinations ▪ Medical (eye examinations received from a health care provider, for diagnosis and treatment of eye condition) Note: The Plan covers eyeglasses or contact lenses (first pair only) within 12 months of cataract surgery. See Section 5, *Additional Coverage Details*, for limits	70% after the Annual Deductible	50% after the Annual Deductible
▪ Routine (Network routine eye exam benefits received from a health care provider once every 24 months) See Section 5, *Additional Coverage Details*, for limits	100% for vision screening	Not Covered
Wigs See Section 5, *Additional Coverage Details*, for more information. There is a lifetime benefit maximum of $750.	100% after the Annual Deductible	100% after the Annual Deductible

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

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

SECTION 5 - ADDITIONAL COVERAGE DETAILS

This section supplements the second table in Section 4, *Schedule of Benefits*, and includes:

■ Covered Health Services for which the Plan pays Benefits; and

■ Covered Health Services that require you to obtain prior authorization before you receive them from Personal Health Support staff.

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

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Applied Behavior Analysis Services for Autism Spectrum Disorder (ASD)

The Plan pays Benefits for behavioral services for ASD (otherwise known as neurodevelopmental disorders), Applied Behavior Analysis (ABA) that are the following:

■ Focused on the treatment of core deficits of Autism Spectrum Disorder.
■ Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
■ Focused on treating maladaptive/stereotypic behaviors that are posing a danger to self, others and property and impairment in daily functioning.

Prior Authorization is required for Applied Behavior Analysis (ABA). Contact UnitedHealthcare for referrals to providers and coordination of care.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 11, *Glossary* for the definition of Emergency Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

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

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

Prior Authorization Requirement

In most cases, UnitedHealthcare will initiate and direct non-Emergency ground or air ambulance transportation. **If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.**

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 11, *Glossary*. For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

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

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

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

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

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

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

Prior Authorization Requirement

For non-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

In addition, for non-Network Benefits you must contact UnitedHealthcare 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Clinical Trials – Routine Patient Care Costs

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI)).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome. UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the number on your UnitedHealthcare Member ID card for information about these guidelines.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

It is important that you notify UnitedHealthcare regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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

- outpatient diagnostic testing;
- evaluation; surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);

- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

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

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

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

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

Dental Services - Accident Only and Oral Care Surgery

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

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

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

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

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

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 36 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;

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

Oral Care

The Plan will pay benefits only for:

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

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

The Plan does not cover:

- dental care, except as described above;
- preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - extraction, restoration and replacement of teeth.
  - medical or surgical treatments of dental conditions.
  - services to improve dental clinical outcomes.
  - dental braces.
  - dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
    - transplant preparation.
    - initiation of immunosuppressives.
    - the direct treatment of acute traumatic Injury, cancer or cleft palate.
    - treatment of congenitally missing, malpositioned, or super numerary teeth even if part of a Congenital Anomaly including but not limited to cleft palate.

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training, Diabetic Eye Examinations, Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items	Insulin pumps and related pump supplies and continuous blood glucose monitors for the management and treatment of diabetes, based upon the medical needs of the Covered Person. Insulin pumps and continuous blood glucose monitors are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section. The medical Plan does not cover the following diabetic self- management items; however, these may be covered under a separate prescription drug plan administered by CVS Caremark: • insulin • insulin syringes with needles; • blood glucose and urine test strips; • ketone test strips and tablets; • lancets and lancet devices; • certain continuous glucose monitor sensors, receivers, and transmitters; and • blood glucose monitors.

Durable Medical Equipment (DME)

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

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

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

Examples of DME include but are not limited to:

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

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

Benefits also include dedicated speech generating devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are

available only after completing a required three-month rental period. Benefits are limited as stated below.

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

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

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every calendar year. Prior authorization is required for electric wheelchairs and scooters. Wheelchairs are only covered every three years unless reviewed and approved by Personal Health Support in instances when there has been a change in the Covered Person's health status.

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

Prior Authorization Requirements
For non-Network Benefits, you must obtain prior authorization before obtaining any Durable Medical Equipment (includes orthotics and electric wheelchairs and scooters, and diabetes equipment for the management and treatment of diabetes) that exceed $1,000 in cost (rental not to exceed purchase price). If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Emergency Health Services

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

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as UnitedHealthcare is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, non-Network Benefits will apply.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

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

True Emergency Eligible Expenses and rendered outside the United States are covered subject to Plan guidelines. Eligible Expenses for true Emergency services received outside the United States will be reimbursed at the Network benefit level subject to the Annual Deductible. If you receive treatment while traveling outside the United States, you will have to pay for the services upfront and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, refer to Section 8, *Claims Procedures*. If you have any questions about Benefits while traveling abroad, please call UnitedHealthcare at the number on your UnitedHealthcare Member ID card.

Non-emergency care when traveling outside the United States is not covered.

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

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

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

Hearing and Hearing Aids

Benefits for hearing exams related to an Injury or Sickness are described under *Physician's Office Services - Sickness and Injury* in this section when performed in a Physician's office setting. Expenses related to the hearing exam and fitting is not included in the hearing aid limit.

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Hearing aids can be purchased Network and non-Network; however, Amounts exceeding the hearing aid allowance maximum is the Covered Person's responsibility and does not apply to any Deductible or Out-of-Pocket Maximum. Benefits are limited:

- $3,000 per hearing impaired ear for a Dependent child up to age 19 every 4 calendar years; or
- $1,500 for Covered Person adult every 5 calendar years

Bone anchored hearing aids are a Covered Health Service for which Benefits are described under *Surgery Outpatient* in this section for Covered Persons who have either of the following:

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

Cochlear Implants and post-cochlear implant aural therapy are Covered Health Services.

Home Health Care

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

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

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

Prior Authorization Requirements

For non-Network Benefits, please remember that you must obtain prior authorization from UnitedHealthcare five business days before receiving services including nutritional counseling or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Hospice Care

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

Any combination of Network and non-Network Benefits are limited to 8 visits per calendar year for bereavement counseling.

Prior Authorization Requirements

For non-Network Benefits, please remember that you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

In addition for non-Network Benefits, you must notify UnitedHealthcare within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

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

Prior Authorization Requirements

Please remember for non-Network Benefits for:

- a scheduled admission, you must obtain prior authorization five business days before admission;
- a non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced by 50% of Eligible Expenses.

In addition, for non-Network Benefits, you must notify UnitedHealthcare within 24 hours of admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Infertility Services

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

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 11, *Glossary*. In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program.

Notification is required:

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

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

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

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

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

Lab, X-Ray and Diagnostics - Outpatient

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

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury in this section when an office visit is billed. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Limited to 18 Presumptive Drug Tests per year.

Limited to 18 Definitive Drug Tests per year.

Prior Authorization Requirements

For non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

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

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include:

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

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

Prior Authorization Requirements

For non-Network Benefits you must obtain prior authorization from UnitedHealthcare for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, five business days before scheduled services are received including diagnostic catheterization and electrophysiology implant. If authorization is not obtained as required, Benefits will be reduced by 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Residential Treatment Centers.

Inpatient treatment and Residential Treatment include room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

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

The Plan does not cover Transitional Living services related to Mental Health/Substance-Related and Addictive Disorder Services.

Prior Authorization Requirement

For non-Network Benefits:

- A scheduled admission for Mental Health Services (including an admission services at a Residential Treatment facility you must obtain prior authorization from UnitedHealthcare five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for non-Network Benefits you must obtain prior authorization from UnitedHealthcare before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment programs, outpatient electro-convulsive treatment; psychological testing, transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to UnitedHealthcare, Benefits will be reduced by 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact UnitedHealthcare at the telephone number on your UnitedHealthcare Member ID Card.

Nutritional Counseling

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

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

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

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;

- phenylketonuria (a genetic disorder diagnosed at infancy);
- diabetes mellitus;
- eating disorders; and
- hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition or mental health condition, except for childhood obesity. Nutritional counseling is not covered for adults if there is a stand-alone diagnosis of obesity. This limit applies to non-preventive nutritional counseling services only.

Childhood Obesity
For a Dependent child ages 3 through 18 years: 4 visit limitation per calendar year for physicians and 4 visit limitation per calendar year for registered dietitians who qualify as determined by their Physician. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.
- You have a 3-month physician supervised diet documented within the last 2 years.

Covered In-Network only. Prior Authorization is required for Obesity Surgery.

Obesity Surgery coverage is limited to once per lifetime.

See *Bariatric Resource Services (BRS)* in *Section 6, Clinical Programs and Resources* for more information on the BRS program. There is no non-Network coverage for obesity surgery.

Ostomy Supplies and Urinary Catheter Supplies

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

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

Pharmaceutical Products - Outpatient

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

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

Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications for the treatment of infertility. Prescription drug pharmacy benefits are administered separately by the Pharmacy Benefits Administrator, CVS Caremark. Please see the "Outpatient Prescription Drug Rider" in this SPD.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital

affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the number on your UnitedHealthcare Member ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs at www.myuhc.com or by calling the number on your UnitedHealthcare Member ID card.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

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

Benefits for preventive services are described under *Preventive Care Services* in this section.

Pregnancy – Maternity Services

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

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

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

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

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

Prior Authorization Requirement

For non-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Healthy Moms and Babies

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

Preventive Care Services

The Plan pays Benefits for properly coded Preventive care services provided by a Network provider on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Co-insurance for certain services may still apply for covered services performed prior to rendering of a preventative care service. For example, the pre-operative colonoscopy visit, Co-insurance may apply. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

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

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

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

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

• For details on Preventive Care Services covered under applicable law visit the Healthcare.gov website at https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults/.

• Another option to view Preventive Care Services specific to age and gender is to visit the UnitedHealthcare preventive care website at http://uhcpreventivecare.com/.

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

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

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

Prosthetic Devices

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

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

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

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

Note: Any combination of Network Benefits and non-Network Benefits is limited for a replacement of a type of prosthetic device once every 2-3 calendar years in accordance with UnitedHealthcare clinical guidelines. Once this limit is reached, Benefits

continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998.

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

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

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

Prior Authorization Requirements
For non-Network Benefits, you must obtain prior authorization from before obtaining prosthetic devices that exceed $1,000 in cost per device. If authorization is not obtained as required, Benefits will be reduced by 50% of Eligible Expenses.

Reconstructive Procedures

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

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.

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

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

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

Prior Authorization Requirement
Please remember for non-Network Benefits for:
- a scheduled admission, you must obtain prior authorization five business days before a scheduled Reconstructive Procedure is performed;
- a non-scheduled Reconstructive Procedure you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from UnitedHealthcare as required, or notification is not provided, Benefits will be reduced by 50% of Eligible Expenses.

In addition, for non-Network Benefits, you must contact UnitedHealthcare 24 hours before an admission for scheduled admissions or as soon as is reasonable possible for non-scheduled admissions (including Emergency admissions).

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

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

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, (when required by state law) must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under Durable Medical Equipment and Prosthetic Devices in this section.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, Autism Spectrum Disorders, or as mandated by Georgia state law.

The following service is not covered: speech therapy treatment for attention deficit disorders, except for diagnosis and medical management, learning disabilities, developmental delays (except as mandated by Georgia state law for treatment of Autism Spectrum Disorders) or for speech disorders (such as stuttering) not related to an acute illness.

Any combination of Network Benefits and non-Network Benefits are limited to:

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

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

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

Skilled Nursing Facility/ Rehabilitation Facility Services

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

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

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for

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

Benefits are available only if:
■ the initial confinement in a Skilled Nursing Facility or Rehabilitation Facility was or will be a cost-effective alternative to an Inpatient Stay in a Hospital; and
■ you will receive skilled care services that are not primarily Custodial Care.

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

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

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

Substance-Related and Addictive Disorder Services

Substance-Related and Addictive Disorder Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. Benefits include the following levels of care:
- Inpatient treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Residential Treatment Centers

Inpatient treatment and Residential Treatment include room and board in a Semi-private Room (a room with two or more beds).

Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services
- Crisis intervention.

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

Prior Authorization Requirements
For non-Network Benefits for:
- A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from UnitedHealthcare five business days before the admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from UnitedHealthcare before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; and

extended outpatient treatment visits with or without medication management.

If prior authorization is not obtained as required, and services are deemed to be medically necessary, benefits will be reduced by 50% of Eligible Expenses.

Surgery – Outpatient

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

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

Prior Authorization Requirement

For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if:

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

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

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

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

Therapeutic Treatments – Outpatient

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

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

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

Benefits under this section include:

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

Prior Authorization Requirement

For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: radiation oncology, dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound.

If you fail to obtain prior authorization as required, Benefits will be reduced by 50% of Eligible Expenses.

Transplantation Services

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

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

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

Benefits are also available for cornea transplants. It is not required that the cornea transplant be performed by a Designated Provider.

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

Non-Network Benefits for transplantation services are not available.

The Plan has specific guidelines regarding Benefits for transplant services. Contact UnitedHealthcare at the number on your UnitedHealthcare Member ID card for information about these guidelines.

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

Travel and Lodging

Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care by a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call UnitedHealthcare's Travel and Lodging team at 1-800-842-0843.

Travel and Lodging Expenses
The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:
Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

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

Virtual Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting UnitedHealthcare at www.myuhc.com or the telephone number on your UnitedHealthcare Member ID card.

Benefits are available for Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for:

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from cancer and/or chemotherapy. Benefits are limited to $750 per Covered Person per lifetime.

SECTION 6 – CLINICAL PROGRAMS AND RESOURCES

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

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

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

NurseLine[SM]

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

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

NurseLine[SM] gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish. NurseLine[SM] is available to you at no cost. To use this convenient service, call the number on your UnitedHealthcare Member ID card.

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

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

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

Reminder Programs

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

- mammograms between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

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

Treatment Decision Support

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

This program offers:

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

Conditions for which this program is available include:

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

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

UnitedHealth Premium℠ Program

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

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

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

www.myuhc.com

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

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit www.myuhc.com and:

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

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the

symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your UnitedHealthcare Member ID card.

Disease and Condition Management Services

Bariatric Resource Services (BRS)

Your Plan offers Bariatric Resource Services (BRS) program for obesity surgery. The BRS program provides you with:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your United Healthcare Member ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

Cancer Support Program

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

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

Disease Management Services

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

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;

- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition.

Examples of support topics include:

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

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

DISEASE MANAGEMENT (DM) PHARMACY PROGRAM

UnitedHealthcare and CVS Caremark include a Disease Management (DM) Pharmacy Program for High Deductible Health Plan Members who are active participants in one of the UnitedHealthcare Disease Management (DM) Programs. The DM Pharmacy Program reimburses Members who participate in a DM program for their cost for *certain* prescription drugs. The goal of the program is to encourage Members to proactively manage their condition and overall health.

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

- Diabetes
- Coronary Artery Disease (CAD)
- Asthma
- Medications for Addiction Treatment

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

- Complete the Health Information Profile (assessment) with a UnitedHealthcare nurse.
- Complete the Sharecare RealAge Test. See the Sharecare section of this SPD.
- Actively participate in scheduled coaching calls with the UnitedHealthcare nurse (minimum 1 call each calendar month).

HDHP Members who qualify for the DM Pharmacy Program will pay for their medications at the time of purchase. CVS Caremark will send ongoing files to UnitedHealthcare to advise UnitedHealthcare the amount of the medication cost paid by the Member. The amount paid by the Member will be credited into the Member's Health Incentive Account (HIA). Once the Member has met the minimum IRS deductible threshold of $1400 for an individual or $2800 for a family, the Member will be eligible to be reimbursed for their pharmacy expenses for the select medications from available funds in the HIA. Once the Member has satisfied their entire Deductible, the member Co-insurance for those medications will then be waived at the time of purchase as available in the account and the member will no longer have to pay for the cost of the medication and wait to receive reimbursement from their HIA.

If you have one of these conditions and are interested in participating in the program and want to learn more about how to qualify for the DM Pharmacy Program, please call UnitedHealthcare at (888) 364-6352.

HealtheNotes℠

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

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence-based medicine as described in Section 11, Glossary under the definition of Covered Health Services.

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

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

Wellness Management Services

Maternity Support Program

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

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

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on your UnitedHealthcare Member ID card. As a program participant, you can always call your nurse with any questions or concerns you might have.

Tobacco Surcharge

Tobacco surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Program. For more information, see the "Well-being Program" that includes the Tobacco Cessation Program in the Sharecare Section of this SPD or go to www.BeWellSHBP.com.

SECTION 7 – EXCLUSIONS: WHAT THE PLAN WILL NOT COVER

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

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

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

Alternative Treatments

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

Dental

1. dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as identified under *Dental Services - Accident Only* in Section 5, *Additional Coverage Details*;
   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - extractions (except for the extraction of fully impacted wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes

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

Devices, Appliances and Prosthetics

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

Drugs

1. prescription drugs for outpatient use that are filled by a prescription order or refill (see coverage under a separate prescription drug plan administered by CVS Caremark);
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by (UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion;
3. growth hormone therapy;
4. non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office; and
5. over the counter drugs and treatments.
6. certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.
7. a Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;
8. a Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;
9. benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
10. compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

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

Foot Care

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

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

- ace bandages;
- gauze and dressings;
- adhesive and adhesive remover;
- diabetic strips, and syringes (this may be covered under a separate prescription drug plan administered by CVS Caremark);
- deodorant;
- pouch covers;
- or any other items not listed as covered as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details*;

This exclusion does not apply to:

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

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

Mental Health, Autism Spectrum Disorder, and Substance-Related and Addictive Disorder Services

In addition to all other exclusions listed in this Section 7, *Exclusion*s, the exclusions listed directly below apply to services described under *Mental Health Services, Autism Spectrum Disorder Services and/or Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the International Classification of Disease section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
3. outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorder.
4. services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
6. outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods);
2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in Section 5, *Additional Coverage Details*;
3. food of any kind. Foods that are not covered include: and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), when approved by UnitedHealthcare. Infant formula available over the counter is always excluded. Enteral feedings are covered when:
   - adequate nutrition cannot be possible by dietary adjustment and/or oral supplements; and
   - the enteral feeding is the sole source of the patient's caloric intake.

   If enteral feedings are approved by UnitedHealthcare, then all of the related equipment is also covered. If feedings are NOT approved then equipment is NOT covered. Enteral nutrition products that are administered orally and related supplies are not covered.
   - minerals or metabolic deficiency formulas (except when approved by Personal Health Support).
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and
4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;
4. guest service;
5. supplies, equipment and similar incidentals for personal comfort. Examples include:
   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;

- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts; - video players;
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides);

6. blepharoplasty (upper or lower eyelid), browplasty, brow lift (except when approved by UnitedHealthcare); and
7. sex transformation operations and related services.

Physical Appearance

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

Procedures and Treatments

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

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

Providers

Services:

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

    This exclusion does not apply to mammography testing.

Reproduction

1. health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment;
2. the following services related to a Gestational Carrier or Surrogate:
   All costs related to reproductive techniques including:
   - Assistive reproductive technology.
   - Artificial insemination.
   - Intrauterine insemination.
   - Obtaining and transferring embryo(s).

   Health care services* including:
   - Inpatient or outpatient prenatal care and/or preventive care.
   - Screenings and/or diagnostic testing.
   - Delivery and post-natal care.

   *The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

All fees including:

- Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
- Surrogate insurance premiums.
- Travel or transportation fees.

3. the following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
   - Donor sperm – The cost of procurement and storage of donor sperm.
4. storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue;
5. the reversal of voluntary sterilization;
6. in vitro fertilization regardless of the reason for treatment;
7. elective surgical, non-surgical or drug induced Pregnancy termination including all related services. (This exclusion does not apply when life of mother is at risk);
8. services provided by a doula (labor aide);
9. parenting, pre-natal or birthing classes;
10. surrogate parenting;
11. infertility monitoring, correction or treatment; and
12. infertility drugs (coverage may be approved for a medical diagnosis not related to infertility treatment if the medical diagnosis meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. UnitedHealthcare must be contacted by your physician to determine coverage).

Services Provided under Another Plan

Services for which coverage is available:

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

Transplants

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

Travel

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

Types of Care

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

6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

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

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes;
4. diagnostic tests that are:
   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
5. expenses for health services and supplies:
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
   - that exceed Eligible Expenses or any specified limitation in this SPD;
6. foreign language and sign language services;
7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
8. health services and supplies that do not meet the definition of a Covered Health Service– see the definition in Section 11, *Glossary*. Covered Health Services are those health services including services, supplies or prescription drugs, which UnitedHealthcare determines to be all of the following:
   - Medically Necessary;
   - described as a Covered Health Service in this Summary Plan Description; and

- not otherwise excluded in this Summary Plan Description under this Section 7, *Exclusions*. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement 2;

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when these are otherwise covered under the Plan when:
    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type;
11. inpatient therapies such as rehabilitation, rehabilitative therapy or restorative therapy, unless significant improvement is expected within a reasonable and generally predictable period of time following an acute illness;
12. transitional living programs, day treatment programs related to senior/adult care treatment, assisted living, non-skilled assisted care, nursing homes, personal care homes, extended care facilities, cognitive remediation therapy;
13. speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, a Congenital Anomaly, or as mandated by state law for treatment of autism;
14. any charge for services, supplies or equipment advertised by the provider as free.

SECTION 8 – CLAIMS PROCEDURES

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

Network Benefits

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider) must send the bill to UnitedHealthcare for review. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your UnitedHealthcare Member ID card.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you must submit a request for payment of Benefits within 12 months following the month of service (this may also be referred to as the timely filing deadline) for non-Network Providers. If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the month of service is the date your Inpatient Stay ends. Claim forms may be obtained from www.myuhc.com, or by contacting Member Services.

Network Providers are subject to contractual timely filing limitations.

If Your Provider Does Not File Your Claim

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

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

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

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

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 10, Coordination of Benefits.

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or UnitedHealthcare from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 9: Coordination of Benefits*.

Health Statements

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

Explanation of Benefits (EOB)

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

Important - Timely Filing of Non-Network Claims

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

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your UnitedHealthcare Member ID card before requesting an appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file an appeal as described in this section.

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

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

What to Do First

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

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

How to Appeal a Medical Determination

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

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

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

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

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

Types of claims

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

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

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your Member ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination.

You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and Member ID number as shown on the UnitedHealthcare Member ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

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

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

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

Pre-Service and Post-Service Claim Appeals

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

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

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

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

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

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you. If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- as otherwise required by applicable law.

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

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

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

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

Standard External Review

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

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

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

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

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review.. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the *IRO*'s request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

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

Expedited External Review

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

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

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

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

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

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs.

UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

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

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

Timing of Appeals Determinations

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

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

Please note that UnitedHealthcare's decision is based only on whether or not Benefits are available under the Plan for the

proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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

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

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

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

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

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

Concurrent Care Claims

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

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

Limitation of Action

You cannot bring any legal action against UnitedHealthcare to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. Any such legal action must be taken within three years from the expiration of the time period in which the request for reimbursement must be submitted or you will lose any rights to bring such action against UnitedHealthcare. Furthermore, you cannot bring any legal action against UnitedHealthcare for any other reason unless you first complete all steps in the appeal process described in this section. Any such legal action must be brought within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such legal action against UnitedHealthcare.

SECTION 9 - COORDINATION OF BENEFITS (COB)

This section includes:

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

Filing a Claim When Coordination of Benefits (COB) applies

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

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

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

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

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

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

How COB Works

- When you or your Dependents are covered by two group health plans, determine which plan is the primary and which is secondary. The primary plan is obligated to pay a claim first, which generally means that it will pay most of the expenses.
- Submit claims to the primary plan first. You will receive a benefit payment from that plan along with an explanation of benefits (EOB).
- Make a copy of the EOB you received from the primary plan, attach it to a claim form and mail both to the secondary plan.

The SHBP will not pay a secondary benefit until you submit the primary plan's EOB. Indicate the name and policy number of the person who has the other coverage and that plan's group number.

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

How to Tell Which Plan is Primary

Generally, a plan is primary when:

- The patient is the Covered Person or employee
- The plan does not have coordination of benefits
- The plan is a Workman's Compensation Plan or an automobile insurance medical benefit

- The other plan is Medicare and the patient is covered under the group plan of an active employee.

Note: Covered Persons under the age 65 may qualify for Medicare because of a covered disability or end-stage renal disease. SHBP coverage will be primary until the Medicare waiting period has been exhausted. Medicare determines the length of time the SHBP coverage is primary.

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

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

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

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

If You Have Dual Plan Coverage

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

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

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

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

Other Forms of Duplicated Benefits

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

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your UnitedHealthcare Member ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Medicare Cross-over Program

The Plan offers a Medicare Cross-over program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

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

You can verify that the automated cross-over took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

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

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

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

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future allowable expenses.

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

Refund of Overpayments

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

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid you, but all or some of the expenses were not paid by you or did not legally have to be paid by you;

- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

If the refund is due from you, and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right.

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

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

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

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.
- We may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized, regardless of whether you have been fully compensated or made whole. No "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.

Right of Recovery

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

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year. Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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

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

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

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

SECTION 11 – GLOSSARY

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

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

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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

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

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

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

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

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

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

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

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

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

BMI – see Body Mass Index (BMI).

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by

Georgia Department of Community Health. The CRS program provides:

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

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

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

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

Coinsurance – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

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

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

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

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

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

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance related and addictive disorders, condition, disease, or its symptoms;
- Medically Necessary;
- included in Sections 4 and 5, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described the Eligibility and Enrollment Provisions document that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.shbp.georgia.gov; and
- not identified in Section 7, *Exclusions*.

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

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);

- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the Eligibility and Enrollment Provisions document that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.shbp.georgia.gov.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:
- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers. You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at www.myuhc.com or the telephone number on your UnitedHealthcare Member ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Services via interactive audio and video modalities.

Durable Medical Equipment (DME) - medical equipment that is all of the following:
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*. Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:
- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

    b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

    c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

    d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

    e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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

EOB - see Explanation of Benefits (EOB)

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

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

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 5, *Additional Coverage Details*.

- If you are not a participant in a qualifying Clinical Trial as described under Section 5, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may,

at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling- counseling by a qualified clinician that includes:

- identifying your potential risks for suspected genetic disorders;
- an individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier – a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

HDHP Option - the SHBP option administered by UnitedHealthcare and described in this SPD.

Health Incentive Account (HIA) - When you complete an activity, well-being incentive credits will be placed into your HIA. Well-being incentive credits in your HIA can help pay for Covered Health Services. This lowers the amount you have to pay.

Health Savings Account (HSA) - An HSA is a tax-advantaged account Employees can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible health plan.

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

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

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

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

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

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and

- Provides Emergency Health Services.

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

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

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

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

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

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

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

Manipulative Treatment - the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary – health care services that are all of the following as determined by the Claims Administrator or its designee, within the Medical Claims Administrator's sole discretion.

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

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

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

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical

Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services.

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

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

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorder Services Administrator – the **(UnitedHealthcare)** organization or individual who provides or arranges Mental Health and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time**.** The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

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

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. The Out-of-Pocket applies to all Covered Health Services under the Plan, including outpatient prescription drugs filled at a Pharmacy. The outpatient prescription drug program is a separate plan administered

by CVS Caremark. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

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

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

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.
Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician as long as the provider type is not otherwise excluded from coverage. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The State Health Benefit Plan.

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

Plan Sponsor - Georgia Department of Community Health.

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

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Preventive Care or Preventive Services – For details on Preventive Care Services covered under applicable law visit the Healthcare.gov website at https://www.healthcare.gov/what- are-my-preventive-care-benefits/adults/. You may also visit the UnitedHealthcare preventive care website at http://uhcpreventivecare.com.

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

In summary, preventive care services provided in an outpatient setting by health care professionals (Physicians, Alternative Facility, and Hospitals) are medical services proven to have beneficial health outcomes and to be safe and effective in early disease detection or disease prevention. Under applicable laws, preventive care services require evidence-based medicine; services rated " A" or " B " by the United States Preventive Services Task Force; Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention immunization recommendations; and Health Resources and Services Administration supported evidence-informed preventive care and screenings.

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

- has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or
- has had screening done within the recommended interval with the findings considered normal; or
- has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals; or

- has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

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

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

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

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person by his/her family. This includes nursing services provided on an inpatient or home-care basis whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount – the amount which Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related Addictive Disorder Services treatment. The facility meets all of the following requirements:

- is established and operated in accordance with applicable state law for Residential Treatment programs; and
- provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator; and

- has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

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

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

SHBP – State Health Benefit Plan. The State Health Benefit Plan is comprised of three self-insured plans established by Georgia law: 1) a plan for State employees (O.C.G.A. § 45-18-2), 2) a plan for teachers (O.C.G.A. § 20-2-881), and 3) a plan for non-certificated public school employees (O.C.G.A. § 20-2-911). Currently, benefit options are the same under all three plans and they are usually referred to together as the State Health Benefit Plan.

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

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider and a third-party vendor. When this program applies, the non-Network provider's billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare.

In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your UnitedHealthcare Member ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

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

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

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

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

Spouse - an individual to whom you are legally married.

Substance-Related Addictive Disorder Services - services for the diagnosis and treatment of alcoholism and substance- related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.

The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

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

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

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

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

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

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

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

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

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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

SECTION 12 - IMPORTANT ADMINISTRATIVE INFORMATION

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

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

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

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

Note: Pharmacy and Wellness benefits are administered separately. CVS Caremark provides pharmacy benefits administration. Sharecare is the Well-Being program administrator.

Information and Records

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

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

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

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

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

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

Covered Person's Rights and Responsibilities

Your Rights as a Covered Person Enrolled in Plan Coverage:

- Have your eligible claims paid and notifications provided in a timely manner.
- Receive information about the Plan and the options available to you.
- Be informed of the process for filing appeals of denied claims.

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

NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your UnitedHealthcare Member ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your UnitedHealthcare Member ID card, TTY 711
UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you. You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your UnitedHealthcare Member ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your UnitedHealthcare Member ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. للطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة عرف العضوية الخاصة بخطتك الصحية، واضغط على 0. (TTY) 711 لهاتف يصنلا
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY
7. Bengali-Bangala	অনবাদেকর অনকরাধ থাে◌েক, আপনার ◌া◌য্ পরের◌নার আই ির ে◌◌◌◌া◌ড এ তা◌ের◌◌◌ভূ ◌ ও ে◌◌র রদকত হকব না এমন ে◌টেরক ◌◌ান ন◌কর ট ◌◌ান ে◌◌রন।
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	◌ាកមា◌ានសិ◌ទ្ធ◌ិ ◌◌ួលជនំ ◌◌ួយ និងព◌ត៌មា◌ាន ជកាសា◌ាបសម◌ាគ ◌ដយមាន◌ិ ◌◌ាល◌ាប◌ំដសា◌ាន◌ៃ◌ិសម◌ាន បកប្រប សម្រួលទ◌◌ួរសពា◌ាទ◌◌ដលខកគ◌ដញ◌◌សំរបសម◌ាជក◌ិ ប៉ុ លមានកត់◌◌កងនុ ប័ណ◌ ID
10. Cherokee	Ꮎ D4Ꮷ ᏯᏁ ᏗCZᏋᏁ Ꮘ4ᏫᏁ ᏂAᏪᎳW it, ᏣᏙᏁ ᏙᏯ ᏯR ᏁᏗAVᏁ ACᏫVᏁ ᎥᎾᏲᏫᏁᎢ, ᏣᏐᎾᏫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711

Language	Translated Taglines
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને િવનo મ◌ૂ ચે મદદ અને તમા◌ે ભાષામોo. માંતી મેળિ◌ાનો અિવકાર છે. ◌ુ ભાવષયા મા◌ે િવનતo. ◌ી કા◌ો, તમારા િ◌ે◌ે થ પ્લાન ID કાડર્ પરની સ◌ૂ ◌ીમo. આપેલ ટોલ-◌ે મેમ્બર ફોન નબર ઉપર કોલ કરો, ◌ દબાિ◌ો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा म◌ सहायता एवं जानकार◌ ननःशल◌ु क प्राप्त करने का अ◌धकार है। दभ◌ु ◌ाषषए के ◌लए अनर◌ु ◌ोि◌ करने के ◌लए, अपने ह◌ैल्थ प◌ि ◌◌ान ID काडर् पर सच◌ू
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランの ID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0 を押してください。TTY 専用番号は 711 です。
28. Karen	နအိဉ်ဒီးတါခွဲးတါယာ်လၢနုကၣ်းန္ဒါဘဉ်တါမၤစၢးဒီးတါဂ့ါတါကျိုးလၢနုကျိဉ်ဒဉ်နဲ၀လၢတလိဉ်ဟ့ဉ်အပူၤဘဉ်နွဉ်လီၤ.လၢတါကယ့နွါပူၤကတီၤကျိုးထံတါတဂၤအဂီၢ်ကျိုးဘဉ်လီတဲဖိအကျိုၤလၢကရၢဖိအတလိဉ်ဟ့ဉ်အပူၤလၢအအိဉ်လၢနုတါအိဉ်ဆူဉ်အိဉ်ချုအတါရဲဉ်တါကျဲၤအကးအလိၤဒီးဆီဉ်လီၤနိၣ်ဂ် 0 တက့ါ.TTY 711

29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID 카드에 기재된 무료 회원 전화번호로 전화하여 0 번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافیەی تەواوی کە کە بڕیارمبەر، ی ارمتەیو زانیار یپێویستت بە زمانی خۆت وەرگریت. بۆ داوکاردنی پلانی پەیوەندیبە بکە بەو ژمارەی تەلەفۆنی خوارەوە، یان سەردانی وێبسایتی پەیوەندیبکە بۆ کارتی یەدی ئا. ئەگەر 0 داشاپ و خۆت وستیەندرو.TTY 711
32. Laotian	ທ ານ ີ ວ ີ ດ ຈ ະ ໄ ດ ້ ຮ ັ ບ ການ ຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ພ ິ ເ ศ ษ ໂ ດ ຍ ບ ໍ ່ ເ ສ ັ ຽ ค ່ า ใ ช ้ จ ่ า ย. ใ ห ้ ข ้ อ ม ู ล ข ่ า ว ส า ร ก ั บ ส ุ ข ภ า พ ข อ ง ท ่ า น ใ น ภ า ษ า ข อ ง ท ่ า น ฟ ร ี
33. Marathi	आपल्याकिंवा आपल्या भाषतेील षवनामलू य मदत आणि मोहहतीी लमळण्याचा अधिकार आहे. दभू ाषकास षवनतं ी करण्यासाठ आपल्या आरोग्य योजना ओळखपत्रावरिं सचू ीबध्द केि ल्याया सदसयास षवनामलू य फोन नबं रवर सपं कड करण्यासाठ दाबा 0. TTY
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ ą́ h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईलंे आफ्नो षामा ाा ःनुलक ंु सयोगोरजनानसाजपरापातग रनअि ः ासाजतपाईयंर िनव् ादस रापातग रजपपाऊ षनप िनज्
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wë rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برایدرخواست مترجم شفاهی با TTY 711 تماس حاصل نمودهو 0 را فشار دهید.

Language	Translated Taglines
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵ ਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਿਵਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹਲਥ ਪਲਾਨ ਆਈਡੀ ਵਿੱਚ ਤੇ ਗੁਏ ਟਾਿੱਲ ਫ਼ਰੀ ਮ◆ਬਰ ਫ਼ਨ◆ ਨੰ ਬਰ ਟੀਟੀ ਾਈ 711 ਤੇ ਕਾਿੱਲ ਕਰੋ, 0 ਿੱਦੇ ਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan- Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܠܐ ܐ ̈ ̈ ̈

55. Thai	คุณมีสิทธิที่จะไดร้ ับความช่วยเหลือและ ขอ้ มู ลในภาษาของคุณ ไดโ้ ดยไม่มีค่าใชจ้ ่าย หากตอ้ งการขอล่ามแปลภาษา โปรดโทรศพั ทถ์ ึงหมายเลขโทรฟรี ที่อยบู่ นบตั รประจาตวั สาหรับแผนสุขภาพของคุณ แลว้กด 0 สาหรับผทู ้ ี่ มีความบกพร่องทางการไดยิ นหรื อการพดู โปรดโทรฯถึงหมายเลข 711
56. Tongan- Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری نمبر فون نمبر پر کال کریں جو آپ کے میلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں TTY
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phj dành cho hội viên được nêu trên thẻ ID chương trinh bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען רופט ,דאלמעטשער א דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. 711 TTY
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

End of Medical Claims Administrator Section

WELLNESS PROGRAM ADMINISTRATOR



Well-Being Program- *Be Well SHBP®*

Well-Being Program Description – *Be Well SHBP®*
State Health Benefit Plan (SHBP) will continue to sponsor Well-Being Programs through the Wellness Program Administrator, Sharecare. Sharecare will provide you with support, new tools and redesigned lifestyle management information you need to improve your own health and well-being. The Sharecare app is a mobile first option that you will find enhances your ability to engage in the program.

Earn Points

Members and their covered spouses are eligible to sign up for an account at www.BeWellSHBP.com, complete the RealAge Test, and participate in healthy actions to earn up to 480 points. Points will not be awarded until after the completion of the RealAge Test. For details or questions go to www.BeWellSHBP.com or call 888-616-6411.

NOTE: All actions must be completed and appropriate documentation submitted by November 30, 2022, including the biometric screening. This can be done at an SHBP-sponsored screening event, by your healthcare provider submitting the 2022 Physician Screening Form, or at a Quest Diagnostics Patient Service Center (PSC). Sharecare must receive this documentation between January 1, 2022 and November 30, 2022. It is your responsibility to ensure your information is complete and all documentation (including the 2022 Physician Screening Form) is received by Sharecare by November 30, 2022. After your physician has completed and signed your 2022 Physician Screening Form, you are allowed to fax the form to Sharecare or you may upload it online.

In 2022, you and your covered spouse are each eligible to earn a well-being reward of up to 480 points when you are enrolled in UnitedHealthcare and complete the well-being activities below between January 1, 2022 and November 30, 2022. That is a family total of 960 points.

You and your covered spouse can each earn 480 points and choose to redeem them for either: 1) a $150 Sharecare Rewards Visa® Prepaid Card to use anywhere Visa is accepted (when redeeming all 480 points earned in 2022) OR 2) 480 well-being incentive credits (to apply toward eligible medical and pharmacy expenses). The points you earn in 2022 can be redeemed for well-being incentive credits in increments of 120.

What to Do	*What You will Earn*
Assess Your Health - Complete the RealAge Test A confidential, online questionnaire that will take about 10 minutes to complete. It is recommended that you complete the RealAge Test early in 2022.	*Earn up to 120 points*
Know Your Numbers – Complete a Biometric Screening (Points to be awarded after the RealAge Test is completed) You have three options: through your physician using the 2022 Physician Screening Form, at an SHBP-sponsored biometric screening event, or at a Quest Diagnostics Patient Service Center (PSC).	*Earn up to 120 points*

What to Do	*What You will Earn*
Take Action (Points to be earned after the RealAge Test is completed) Complete Well-being Coaching, Online Challenges, RealAge Program, or a Combination of all Three. **Well-being Coaching** Actively engage in coaching. Earn 40 points for one completed coaching session per calendar month. You can earn 40 points up to 6 times, for a maximum of 240 points **Online Challenges** Earn 120 points up to 2 times, for a maximum of 240 points by joining and completing two of the following challenges within the challenge period as listed below: • *Steps Challenge (track 7,000 steps per day for 21 days in January, April, July, or October)* • *Stress Challenge (track calm or productive stress levels for 21 days in February, May, August, or November)* • *Green Day Challenge (log 8 Green Day trackers per day for 21 days in March, June, or September)* ***NOTE:*** For more details, go to www.BeWellSHBP.com. **RealAge Program** Earn 120 points one time for completing the RealAge Program. You may start at any time during the program year, but once started you must track at least 4 times a week (Sunday- Saturday) over 3 weeks to be awarded points.	*Earn up to 240 points* ***NOTE:*** *You may complete as many coaching sessions as you like in a month; however, a maximum of one session in a calendar month qualifies you for the 40 points.* ***NOTE:*** *Points cannot be awarded until completion of the RealAge Test. Biometrics, Coaching, RealAge Program, and Online Challenges completed before completion of the RealAge Test can only be applied to points upon RealAge Test completion.*
Note: If you terminate your coverage with SHBP, any unused HIA credits will be forfeited.	

Points are saved in the Sharecare Redemption Center until you choose to redeem them, meaning points will not be sent automatically to UnitedHealthcare. Therefore, you and your covered spouse must make your selection on how you choose to redeem your points through the Redemption Center, by visiting www.BeWellSHBP.com.

If you elect to redeem all 480 points earned in 2022 for the $150 Sharecare Rewards Visa® Prepaid Card it will be physically mailed within 8 weeks of redemption. If you elect to redeem your points for well-being incentive credits to apply toward eligible medical and pharmacy expenses, you may do so in increments of 120 (up to a maximum of 480). Well-being incentive credits will be available within 30 days of redemption and will be deposited into your HIA account. Note: Once you redeem any of the 2022 points for well-being incentive credits you will no longer be able to select the Prepaid Visa Card option. You must redeem your points for only one of the available two options.

Getting Started

To get started log onto www.BeWellSHBP.com and follow the instructions to register and take your RealAge Test. You will be asked to enter six registration credentials of First Name, Last Name, Date of Birth, Gender, Zip Code and the last four digits of your Social Security Number (SSN).

Note: To access the Sharecare App that is specific to SHBP members, **you must** go to www.BeWellSHBP.com and sign up first. You can then download the Sharecare app, but you will need to use the same log in information used on the website to ensure your account is linked.

Well-Being Incentive Credit Rollover Between Plan Options and Medical Claims Administrators

All unused well-being incentive credits redeemed while participating in the SHBP Well-Being Program called *Be Well SHBP*® will roll over whether you remained enrolled in your current Plan Option and medical claims administrator or changed to another Plan Option and/or medical claims administrator.

This means no matter which Plan Option you select (excluding TRICARE Supplement); you will not forfeit any unused well-being incentive credits that have been redeemed.

Note: Unused well-being incentive credits will rollover in April 2022. This allows unused well-being incentive credits to be used to pay your out-of-pocket expenses for 2021 claims filed after December 31, 2021. There is a date limitation to when you may use the 2021 rollover credits for reimbursement. Only eligible medical expenses incurred after the rollover in April 2022 will qualify for reimbursement using the 2021 well-being incentive credit rollover funds. Expenses for services incurred from January to March 2022 are not eligible for reimbursement from 2021 rollover credits. However, until your 2021 credits roll over, any 2022 well-being incentive credits earned and available at the time claims are received by UnitedHealthcare may be used for those expenses during this time period.

For members transferring into an SHBP Medicare Advantage Plan
Remember to redeem points before transferring into an SHBP Medicare Advantage Plan as points are not automatically redeemed and transferred for Medicare Advantage members. Any unused well-being incentive credits will remain in your HIA for a six month run out period, to allow for prior year's claims processing. If you have a balance of 100 credits or more in your HIA after being enrolled in Medicare Advantage for at least six months and are not in a split option, an individual Retiree Reimbursement Account (RRA) will be set up by your Medicare Advantage Plan Administrator, Anthem or UnitedHealthcare.

Credits remain with the active Commercial Plan Option if you have a spouse and/or dependent(s) who are still on that plan. If there are any credits remaining once the last Commercial member moves to Medicare Advantage, the credits will follow that member. Once you move over to a Medicare Advantage Plan Option, you are no longer eligible to earn points with Sharecare.

Sharecare Well-Being Services

You can access the *Be Well SHBP*® well-being program at, www.BeWellSHBP.com. The key components of the program are listed below.

- RealAge Test: A clinically validated health risk assessment.
- Daily Trackers (Green Days): Engagement data to track key RealAge Test health indicators.
- Digital Health Programs: Personalized recommendations, suggested content, targeted insights, and customized messages.
- Content Library: Articles, questions and answers, videos, health topics, and much more.
- AskMD: Evidence-based and customizable symptom checker tool.
- Personal Health Profile: Personal health record where members can access their health history in one place.
- Mobile Application and Smart Phone Technology: The Sharecare App places the power of the Sharecare App in the hands of smart phone users.
- Online Campaigns and Challenges: The Groups and Challenges feature allows Members to interact with one another, or compete against one another in pre-defined challenges for walking (steps program), exercise, stress management, and healthy living.
- RealAge Program: Upon completion of the RealAge® Test you can begin participating in the RealAge® Program, a comprehensive healthy behavior program targeting the 4 highest lifestyle risks – Stress, Sleep, Nutrition and Activity.
- Device integration to promote fitness, exercise and health and Well-Being: Members using the Sharecare App can link their own devices to the trackers. Once linked, the device will share its data with the application automatically updating the Green Day Trackers. Members may also rely on their personal cell phone to establish some trackers, not relying on an external device. Members are responsible for making sure that the information is properly tracked.
- Points and Rewards Tracking: Your incentive status will be listed under the Rewards section of the Sharecare App or online. Please be sure to first register on www.BeWellSHBP.com and complete your RealAge Test through the Sharecare App or online.

Sharecare RealAge Test

The RealAge Test is Sharecare's clinically-validated health risk assessment that guides you through a series of questions designed to gauge how fast you're aging based on your lifestyle, genetics, and medical history as well as often overlooked risk factors like relationships and stress. RealAge is your first step to get started with Sharecare, as it helps you understand which of your lifestyle habits are impacting your health. From there, Sharecare provides you with content and programs to help you improve your overall health and obtain a younger RealAge. It takes about 10 minutes to complete the RealAge Test. The answers you provide will not be shared with your employer or SHBP.

Biometric Screenings

A Biometric Screening provides an excellent opportunity to know your biometric numbers and what they mean for you. The screening typically takes 15-20 minutes. During a biometric screening event, a health professional will collect measurements, including body mass index (BMI), blood pressure, cholesterol, glucose, and hemoglobin A1c (HbA1c). In 2022, SHBP Members and their covered spouses will have the opportunity to obtain a biometric screening at their personal Physician's office, at an SHBP-sponsored biometric screening event, or at a Quest Patient Service Center (PSC). For information on biometric screenings, please visit www.BeWellSHBP.com or call Sharecare at 888-616-6411.

2022 Physician Screening Form

You may complete your screening with your Physician and utilize an easy-to-use 2022 Physician Screening Form. The form can be accessed through www.BeWellSHBP.com, printed from your computer and taken to your Physician for completion. Each individual will need to log in and enter their first and last name as it appears on their UnitedHealthcare Member ID card, date of birth, zip code and gender to pre-populate the form. Any 2022 Physician Screening Forms not pre-populated will not be processed. The 2022 Physician Screening Form processing oversight is handled by Sharecare.

If the 2022 Physician Screening Form submitted by your Physician is incomplete (i.e., missing pre- populated Member information, missing Physician signature or participant signature), your form will not be processed. In order to process your

form and have your results loaded, you will need to work with your physician's office to ensure that the form is signed and submitted by the deadline of November 30, 2022. If your form is signed, but only partially completed, your form will be processed as is and will only show results for the data provided. Points will only be awarded when all of the results are complete. For information on Physician Screening Forms, please visit www.BeWellSHBP.com or call 888-616-6411.

It is your responsibility to ensure your information is complete and all documentation (including the 2022 Physician Screening Form) is received by Sharecare by November 30, 2022. After your physician has completed and signed your Physician Screening Form, you may upload the form online or fax the form to Sharecare if necessary.

Well-Being Coaching

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

Well-Being Coaches maintain confidentiality and work to establish attainable goals collaboratively with you. Your coach will have confidential access to your Well-Being Plan, including your RealAge Test and biometric data, and will be able to see your progress towards your goals. Well-Being Coaching support is provided as long as you need it. Additionally, you can make unlimited in-bound calls for ongoing support as needed.

Individuals identified for coaching will be directly contacted to enroll in the Well-Being Coaching program. Individuals not identified for coaching support may self-enroll online or by calling 888-616-6411. If you wish to unenroll from coaching calls, please call 888-616-6411.

Online Challenges

Within the Sharecare app or online platform, join and complete monthly challenges:

- Complete 7,000 Steps per day for at least 21 days within the challenge period; or
- Track calm or productive stress levels for at least 21 days within the challenge period; or
- Log 8 Green Day trackers (such as steps, sleep, stress, blood pressure, weight, and smoking) per day for 21 days within the challenge period.

RealAge Program

Upon completion of the RealAge® Test (within the Sharecare app or the online platform) you can begin participating in the RealAge® Program, a comprehensive healthy behavior program targeting the 4 highest lifestyle risks – Stress, Sleep, Nutrition and Activity.

Family Centered Well-Being

The *Be Well SHBP*® program is focused on Family centered well-being. Log onto www.BeWellSHBP.com to learn more about the resources available to support members and their families.

Live Chat

Enables Members to directly outreach to member services staff.

Onsite Well-being Support

Presentations and webinars given at your worksite on a variety of topics including healthy eating, family well-being, increasing physical activity, stress management, preventive care and more. Worksite Well-Being ambassadors program to keep you informed and motivated.

Well-Being Incentive Tracking

Through Sharecare's Redemption Center, the Rewards section of the Sharecare App or online, you can see up to date statuses regarding points. This includes completion of the RealAge Test and biometric screening, enrollment and engagement in Well-Being Coaching, and online challenges and programs. Please be sure to first register on www.BeWellSHBP.com and complete your RealAge Test through the Sharecare App or online. You can perform a screen print function to show evidence that you completed the required activities for program completion.

Timelines for Actions to be Posted

The RealAge Test will be live on January 1, 2022. Immediately after taking the RealAge Test you can begin participating in the online challenges, a RealAge Program, and you will receive personalized messaging and much more meant just for you. You have until November 30, 2022 to complete the activities to earn points for 2022.

You and your covered spouse can each earn up to 480 points and choose to redeem them for either: 1) a $150 Sharecare Rewards Visa® Prepaid Card to use anywhere Visa is accepted (when redeeming all 480 points earned in 2022) OR 2) 480 well-being incentive credits (to apply toward eligible medical and pharmacy expenses). The points you earn in 2022 can be redeemed for well-being incentive credits in increments of 120.

The 2022 action-based points will be earned as the action is completed and will be available as credits in your incentive account within 30 days after redemption.

Points are saved in the Sharecare Redemption Center until you choose to redeem them. All points must be redeemed by midnight Eastern Time on December 15, 2022. Points not redeemed by **December 15, 2022** will be sent to your respective SHBP Medical Claims Administrator as well-being incentive credits to be used towards eligible medical and pharmacy expenses.

You will not be able to select the Prepaid Visa Card option if you begin redeeming points to apply towards your well-being incentive credits.

You must complete all well-being activities totaling 480 points in order to select the $150 Prepaid Visa Card option. The card will be physically mailed within 8 weeks of redemption.

Actions must be completed between January 1, 2022 and November 30, 2022 to earn the 2022 points.

If your points are not properly displaying in the Rewards section of the Sharecare App or in the Sharecare Redemption Center, please call Sharecare at 888-616-6411.

Tobacco Surcharge Policies and Cessation

Tobacco Surcharge

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

Go to www.shbp.georgia.gov to access the tobacco surcharge removal policies and forms. These policies allow you to have the tobacco surcharge removed by completing the tobacco surcharge removal requirements through Sharecare. **The Tobacco Surcharge Removal Policy applies to tobacco and electronic nicotine delivery systems (also known as vapes or e-cigarettes).**

If you and your enrolled Dependents complete the Tobacco Surcharge removal requirements, you will be able to avoid the surcharge for the entire year. This means that any surcharge paid in 2022 may be refunded after the completion of the tobacco surcharge removal requirements. The tobacco surcharge removal requirements must all be completed in 2022. Contact Sharecare at 888-616-6411 for more information.

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

Telephonic Well-Being Coaching and Online Program for Tobacco Cessation

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

- Phone coaching sessions with a trained counselor
- Access to Nicotine Replacement Therapy coverage – see Pharmacy Benefits Administrator section
- Self-refer into coaching or online support via www.BeWellSHBP.com

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

2022 Well-Being Incentive Appeal Process

If you or your covered spouse, or both, are advised that your 2022 points were not obtained, you may appeal this decision directly to Sharecare. Appeals, along with the requested documents, must be submitted by 5:00 pm, ET **January 31, 2023.** Points Appeals submitted after this date will be denied.

All appeals approved on or after December 1, 2022 will apply towards redemption of well-being incentive credits. The Prepaid Visa Card will not be an option.

Level 1 – Points Appeals
To file a Points Appeal, complete all applicable sections on the Level 1 - 2022 Points Appeal Form located at www.BeWellSHBP.com, sign and date the form. If the 2022 Well-Being Activity in question was not satisfied due to circumstances beyond your control, you should explain why in the space provided on the Level 1 - 2022 Points Appeal Form. Examples of "circumstances beyond your control" include, but are not limited to, the following: long-term hospital stay and hospice stay.

You should submit the form, along with the supporting documentation, to the email, fax or mailing address located on the Level 1 - 2022 Points Appeal Form. An example of appropriate supporting documentation includes:

- A copy of the completed 2022 Physician Screening Form and confirmation that it was sent to Sharecare by the November 30, 2022 deadline (if applicable).
- A copy of the Know Your Numbers Form as proof on onsite screening participation upon completion at a SHBP-sponsored screening event.
- Print screen or take a snapshot of the incentive status when activities through the Sharecare App or online are complete.

Level 2 – Formal Appeal
If your 2022 Points Appeal is denied, you may file a Formal Appeal, which must be postmarked within fifteen (15) calendar days following the date of the 2022 Level 1 Points Appeal decision. To file a Formal Appeal, you must complete the Level 2 – 2022 Points Appeal Form and attach a copy of the 2022 Level 1 Appeal decision, along with any supporting documentation. The Level 2 - 2022 Points Appeal form is located at www.BeWellSHBP.com. Instructions are included on the form.

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

Please forward all written requests for Formal Appeals along with a completed Level 2-2022 Points Appeal Form to the email, fax or mailing address located on the Appeal Form. The appeal form is available at www.BeWellSHBP.com.

Sharecare Definitions

RealAge Test
The RealAge Test is Sharecare's clinically-validated health risk assessment that guides you through a series of questions designed to gauge how fast you're aging based on your lifestyle, genetics, and medical history as well as often overlooked risk factors like relationships and stress. The RealAge Test is your first step to get started with Sharecare, as it helps you understand which of your good and bad habits are impacting your health. From there, Sharecare provides you with content and programs to help you improve your overall health and obtain a younger RealAge. It takes about 10 minutes to complete the RealAge Test. The answers you provide will not be shared with your employer or SHBP.

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

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

Well-Being Coaching
Well-Being Coaching helps you find opportunities to improve well-being every day. Through convenient phone-based sessions, Well-Being Coaching guides you through healthy behavior changes by building on your strengths. The program is confidential, voluntary, and offered to you as part of your plan benefits at no additional cost to you. You decide if you want to participate and how involved you want to be. All calls are scheduled at your convenience and on your timeline. With help from Well-Being Coaching you can:

- Better understand your health risks
- Get answers to your health questions
- Find support to gain more control over your health
- Set goals to reach your healthy best

Sharecare App
The Sharecare App is a health and wellness engagement mobile tool that provides personalized information, programs and resources to improve your health. It provides personalized information to you based on your response to the RealAge Test.

Health Profile
Provides an overview of all your health data in one place based on the results of your RealAge Test, trackers, AskMD, and with your permission, can include data ingested from your biometrics and claims.

Green Day Tracker
Sharecare Green Day Tracker (GDT) includes daily trackers, which are core to the RealAge calculation. The trackers include, steps, sleep, stress, relationships, blood pressure, weight, smoking exposure, cholesterol, alcohol, fitness and health, diet, medication adherence, and blood glucose. In order to accomplish a Green Day, you will need to enter data for 8 trackers within the green range daily to improve your RealAge.

End of the Wellness Program Administrator Section

PHARMACY BENEFITS ADMINISTRATOR



OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider to the Summary Plan Description (SPD) provides Benefits for outpatient Prescription Drug Products. CVS Caremark administers your Prescription Drug Pharmacy Benefits. Because this Rider is part of a legal document, we want to give you information about this document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the CVS Caremark Pharmacy Definition Section. When we use the words "we," "us" and "our" in this document, we are referring to Department of Community Health (DCH), State Health Benefit Plan (SHBP) Division. When we use the words "you" and "your," we are referring to people who are Covered Members.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy, CVS Caremark Mail Order, CVS Specialty or an out- of-network pharmacy.

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

CVS Caremark administers the pharmacy benefits for Members and their Covered Dependent(s) enrolled in UnitedHealthcare Non-Medicare Advantage Plan Options for 2022.

Note: Members do not have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their Covered Dependent(s) can continue to use local retail and/ or chain pharmacies to obtain their prescription medications. Please visit the CVS Caremark's pharmacy locator tool to find a network pharmacy near you.

Benefits for Outpatient Prescription Drug Products

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

Benefits are available for outpatient Prescription Drug Products on the CVS Caremark Preferred Drug List (PDL), which meet the definition of a covered health service and are dispensed at a licensed pharmacy. Co-insurance (or other payments you are responsible for will vary depending on the outpatient Prescription Drug Product's placement within the three (3) tiers of the CVS Caremark PDL. See the Prescription Drug Pharmacy Benefits Co-insurance table in the "Schedule of Benefits" Section.

Payment Information

Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on which tier the drug falls into and is determined by CVS Caremark, the Pharmacy Benefits Administrator. Co-insurance amounts will not be overridden or changed on an individual basis.

Note: Co-insurance amounts apply toward the deductible and the Out-of-Pocket Maximum.

High Deductible Health Plan	
Prescription Drug Pharmacy Benefits Co-insurance payments you must pay	
31-day supply for a participating Retail Network Pharmacy	
Tier 1: Co-insurance (Generic drugs and some select preferred Brand-name drugs)	30% Co-insurance after Deductible is met for up to 31-day supply
Tier 2: Co-insurance (preferred drugs)	30% Co-insurance after Deductible is met for up to 31-day supply
Tier 3: Co-insurance (non-preferred drugs)	30% Co-insurance after Deductible is met for up to 31-day supply
90-day Supply for maintenance drugs from mail order <u>OR</u> a Retail Network Pharmacy	
Tier 1: Co-insurance (Generic and some select preferred Brand-name drugs)	30% Co-insurance after Deductible is met for up to a 90-day supply
Tier 2: Co-insurance (preferred drugs)	30% Co-insurance after Deductible is met for up to a 90-day supply
Tier 3: Co-insurance (non-preferred drugs)	30% Co-insurance after Deductible is met for up to a 90-day supply

If a Generic product is available and you or your physician choose to use the Branded product instead, then you will pay the applicable Brand Co-insurance plus the cost difference between the Generic product and its Brand product (what is called the Ancillary Charge). This Ancillary Charge will apply towards your deductible and your Out-of-Pocket Maximum.

Out-of-Network pharmacy expenses are paid at 70% of the Network contracted rate after the deductible has been met.

Note: Preferred insulin will pay at a Tier 1 Co-insurance and Non-preferred insulin will pay at a Tier 2 Co-insurance. Please refer to the Preferred Drug List by visiting info.caremark.com/shbp.

For Prescription Drug Products at a participating Retail Network Pharmacy, after the deductible is met, you are responsible for paying:

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

For Prescription Drug Products from the CVS Caremark Mail Order Pharmacy or CVS Specialty, after the deductible is met, you are responsible for paying:

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

Coverage Policies and Guidelines
Your CVS Caremark pharmacy benefit provides coverage for a comprehensive selection of Prescription medications. The most commonly prescribed medications for certain conditions are named or described in the 2022 Preferred Drug List (PDL).

Your Plan will have Prescription Medications Placed in Tiers.
Prescription medications are categorized within three (3) tiers which are determined by the Pharmacy Benefits Administrator. Each tier is assigned a Co-insurance amount which is determined by the Plan. Please consult the CVS Caremark Preferred Drug List at info.caremark.com/shbp, or call the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card for the most up-to-date tier status of your medication(s) and any associated coverage rules (including supply limits, PA requirements, etc.).

The Preferred drug list is developed by CVS Caremark. This list is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. Selection criteria sources include but are not limited to: peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the FDA; and input from medical specialty practitioners.

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

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. If such a change happens, the coverage rules applied to that drug may change. Tier status and Co-insurance will not be overridden or changed for an individual member.

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

If you do not show your UnitedHealthcare Member ID Card at a Network Pharmacy, you will be required to pay the Full Retail Cost.

CVS Specialty
Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether the drugs are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. Drugs which have been identified as Specialty Prescription Drugs for your benefit plan are listed on the CVS Caremark website info.caremark.com/shbp. Your prescriptions do not have to be filled through CVS Specialty home delivery program if you have a prescription for one of these products. See "Glossary and Definitions" for definitions of Specialty Prescription Drug Product and Designated Pharmacy. See "What's Covered-Prescription Drug Benefits" Section for more information on Specialty Prescription Drug Product.

Care Management Program – Complex Conditions
CVS Health will provide a differentiated care management program that focuses on proactive holistic patient care, including comorbidity management for members with complex conditions requiring specialty pharmacy care. Once enrolled, a dedicated and highly trained care management nurse can proactively provide support to better manage a member's whole condition through evidence-based interventions, comprehensive patient education, medication, and symptom management – while being available 24/7.

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

Member Rights and Responsibilities
As a member, you have the right to express concerns about your SHBP coverage and to expect an unbiased resolution of your individual issues. You have the right to submit a written appeal or inquiry regarding any concern that you may have about the prescription drug program or your drug coverage.

CVS Caremark Customer Care
Written appeals and inquiries related to the prescription drug program should be directed to:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072

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

WHAT IS COVERED - PRESCRIPTION DRUG BENEFITS

CVS Caremark will provide Pharmacy Benefits under the plan for outpatient Prescription Drug Products:

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

Benefits for Outpatient Prescription Drug Products

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

Benefits for outpatient Prescription Drug Products are available through three types of Network pharmacies: Retail Network Pharmacies; the CVS Caremark Mail Order; and CVS Specialty. You can obtain information about participating Retail Network Pharmacies by calling the toll-free number on your UnitedHealthcare Member ID card, or on the web at info.caremark.com/shbp.

Covered Members that enroll in Disease Management for Diabetes, Coronary Artery Disease (CAD), Asthma, or Medications for Addiction Treatment may qualify for the Disease Management (DM) Pharmacy Co-insurance Waiver Program, which allows you to get select medications for these disease states at zero Co-insurance after your deductible has been met. If you have one of these conditions and are interested in participating in the Personal Health Coach Program and learning more about how to qualify for the Co-insurance waiver incentive, please call UnitedHealthcare Member Services toll-free at 855-641-4862.

When a Brand-name Drug Becomes Available as a Generic

When a Brand-name drug becomes available as a Generic Prescription Drug Product, the cost of the Brand-name Prescription Drug Product may change, and therefore your Co-insurance may change. You will pay the applicable Co-insurance for the Prescription Drug Product. If you or your physician request a Brand-name Prescription Drug Product in place of the chemically equivalent Generic Prescription Drug Product (Generic equivalent), you will pay the applicable Brand Co-insurance amount as well as the difference in cost between the Brand and Generic Drug Product (Ancillary Charge). The Ancillary Charge will count towards your deductible and your Out-of-Pocket Maximum.

When You will be Required to Change from a Generic to a Brand-name Medication

Making sure you have access to affordable medications is our priority. To keep costs low, your plan covers a specific list of medications that may change occasionally that will require you to change from a Generic to a Brand-name medication. If this happens, you'll be notified of the change by mail. The good news is you will not need a new prescription and the Brand-name medication will be at the same tier Co-insurance as the Generic.

If you continue to fill prescriptions for the Generic medications that will no longer be covered by your plan, you will have to pay the entire cost. To avoid this, change to the Brand-name medication by asking your pharmacist to fill your prescription with the Brand-name medication. If you have questions about your prescription drug coverage, call Customer Care at 1-844-345-3241.

Supply Limits

With the required Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. You may determine if a Prescription drug has been assigned a supply limit by calling the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card or on the web at info.caremark.com/shbp.

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

Network Pharmacy Prior Authorization or Coverage Review Requirements

When Prescription Drug Products are dispensed at a Network Pharmacy and require Prior Authorization (PA), the prescribing Provider or Pharmacist are responsible for requesting approval from CVS Caremark. If a PA has not been approved or submitted for approval before the Prescription Drug Product is dispensed at a participating Network Pharmacy,

then the prescription is not eligible for coverage and you will be required to pay the Full Retail Cost (Usual and Customary Charge) for that prescription at the pharmacy. If a PA is requested within twelve (12) months after the date the prescription was filled and the PA is retroactively approved, then you may request reimbursement from CVS Caremark. The Prescription Drug Products requiring PA are subject to periodic review and modification. You may find out whether a particular Prescription Drug Product requires PA by consulting your PDL through info.caremark.com/shbp or by calling the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card.

Note: Prior Authorization approval will be required before the claim will be considered for reimbursement. If CVS Caremark is notified within twelve (12) months after you pay the Full Retail Cost and the Prior Authorization is denied, you will not be reimbursed.

Requesting Reimbursement for a claim you paid Full Retail Cost

If a prescription is filled by an Out-of-Network Pharmacy or without use of your UnitedHealthcare Member ID Card you can submit that claim for reimbursement up to twelve (12) months after the date the prescription was filled. If the drug required Prior Authorization approval and that was not obtained prior to filling the prescription, then it can be requested at the time the claim is submitted. If the Prior Authorization is not approved, then you will not be able to be reimbursed for your claim.

When you submit a claim on this basis, you may pay more because you did not notify CVS Caremark before the Prescription Drug Product was dispensed and because the Out-of-Network Pharmacy you used is not bound by the network pricing under our plan. The amount you are reimbursed will be based on the Network Prescription Drug Cost, less the required Co-insurance and Ancillary Charge, if applicable. Reimbursement will be provided after you have met your deductible.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from CVS Caremark by calling the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card, or log into info.caremark.com/shbp. Along with the prescription drug claim form, you will need a pharmacy receipt for your prescription and if applicable- an explanation of benefits (EOB) from your primary carrier, if you are submitting your pharmacy claim for secondary coverage.

The prescription drug claim form must be filled out in its entirety and mailed to the address on this form. Any missing information may cause a delay in processing.

Step Therapy Program Requirements

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or pharmaceutical products, for which Benefits are described in your Summary Plan Description (SPD), are subject to Step Therapy Program requirements (also known as Step Therapy or ST). This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products, you are required to use a different Prescription Drug Product first.

You may determine whether a particular Prescription Drug Product or pharmaceutical product is subject to Step Therapy requirements through info.caremark.com/shbp or by calling the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card.

Clinical Appeal Process

If a Prior Authorization or quantity limitation request is denied by CVS Caremark, you or your physician may initiate the clinical appeals process. CVS Caremark recommends that a physician initiate an appeal for a denied Prior Authorization decision by CVS Caremark so that all necessary clinical information can be obtained.

The request/appeal must be submitted in writing (via letter) to CVS Caremark for consideration. The appeal must be submitted within 180 calendar days of the date of the denial letter. This is known as the first-level appeal. The written inquiry should be directed to:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 866-443-1172

CVS Caremark will advise you in writing of its decision. If CVS Caremark upholds the denial, information regarding the second-level appeal process will be provided to you.

Second-level appeals (an appeal of the first-level appeal decision described above) must be initiated by you or your authorized representative and must be received in writing (via letter). CVS Caremark recommends that a Physician initiate an appeal for a denied first- level appeal decision by CVS Caremark so that all necessary clinical information can be obtained. The second-level appeal must be submitted within 60 calendar days of the date of the first-level appeal denial letter.

The second-level appeal request, along with any new and/or additional supporting documentation, shall be forwarded to CVS Caremark to the address above.

If, after exhausting the two levels of appeal available to you under your plan, you are not satisfied with the second-level appeal determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for experimental, investigational or unproven services.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact CVS Caremark at the toll-free number on your UnitedHealthcare Member ID Card for more information.

Preventive Care Medications

Patient Protection Affordable Care Act, Preventive Care Medications, and over-the-counter (OTC) medications are covered as described in the "Prescription Drug Glossary and Definition" in this Section of the SPD. For these Preventive Care Medications to be covered, you must obtain a prescription from your Doctor and meet any specified requirements. As part of the Patient Protection and Affordable Care Act, certain Prescription Drug Products are covered as Preventive Care Medications at no cost to the Member. You may determine whether a drug is a Preventive Care Medication by calling the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card or through the website info.caremark.com/shbp. You may not be responsible for paying Co-insurance for these Preventive Care Medications.

The HDHP Plan also includes a HDHP generic maintenance drug list. There are some medications that can help prevent disease or help manage existing conditions to prevent further complications. For this reason, the State Health Benefit Plan offers a generic maintenance drug list, which reduces your cost for select medications that help prevent or manage some chronic health conditions. If you take medications on the generic maintenance drug list, you do not have to meet the deductible before your Co-insurance rate is applied. You will pay the 30% Co-insurance beginning on your first fill of these select medications on the approved list. If you have questions about the HDHP generic maintenance drug list, call CVS Caremark Customer Care on the back of your UnitedHealthcare Member ID card or go to info.caremark.com/shbp.

Tobacco Cessation Medications

A total of two (2) 84-day treatment cycles of certain OTC or prescription tobacco cessation medications is available through a Retail Network Pharmacy at no cost to the member per year. A prescription is required for coverage. For a list of the covered tobacco cessation medications, go to info.caremark.com/shbp.

The Tobacco Cessation programs are available to Covered Members age 18 and older to assist them to become tobacco-free. Please see the Tobacco Cessation section in the Wellness Administrator section of this SPD. To enroll in the Tobacco Cessation program, please call Sharecare at 888-616-6411.

Patient Safety

CVS Caremark monitors for potential safety issues with drug therapy and will communicate alerts to the pharmacist at the point-of-sale and directly to the prescribing physicians when appropriate.

Coordination of Benefits (COB)

If your spouse or a dependent has coverage from another health plan, the prescription drug benefits provided by the SHBP will be coordinated with the other insurance carrier(s). This means you must present both prescription plans to the pharmacy when filling your prescription. If your other coverage pays as primary then you can request a secondary payment under your SHBP plan from CVS Caremark at the time of purchase. To do this, just request the pharmacist to electronically file SHBP secondary (see below).

Coordination of Pharmacy Benefits between your Medicare Part D plan and SHBP

- If you have a Medicare Part D plan, each time you go to the pharmacy, present both your Medicare Part D and SHBP UnitedHealthcare Member ID cards.
- When you reach the Medicare Part D coverage gap, you should still present both identification cards and you will pay your SHBP Co-insurance.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Prior Authorization and step therapy, receive approval before your claims may be considered for reimbursement.

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan (PDP) and SHBP

If you have coverage under another health plan, each time you go to the pharmacy, present both your primary insurance carrier and SHBP UnitedHealthcare Member ID cards.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your other insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Prior Authorization and Step Therapy, receive approval before your claims may be considered for reimbursement.

To request a secondary payment from CVS Caremark after the time of purchase, you can send a prescription drug claim form and attach a copy of the EOB from the primary plan and the pharmacy receipt. You can obtain a copy of the prescription drug claim form by calling the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card, or through info.caremark.com/shbp.

When the SHBP is the secondary plan, benefits are coordinated to pay only the difference between the amount paid by the primary plan and the allowable amount payable by the SHBP, less any applicable Co-insurance.

Note: The amount paid as secondary payor will not exceed the allowable amount payable by the SHBP as primary payor. Please call the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card for more details. If you have coverage under two SHBP contracts (cross-coverage or dual coverage), Prescription Drug Benefits provided by the SHBP will not be coordinated. Co-insurance will be required for each filled prescription. If you have coverage under a Medicare Advantage plan, benefits provided by the SHBP pharmacy benefits will not be coordinated.

Pharmacy Type and Supply Limits

Prescription Drugs from a Participating Retail Network Pharmacy

The following supply limits apply for each fill of medication:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits established for a particular drug under the plan.
- You may obtain a three-month supply at one time for drugs identified by CVS Caremark as maintenance medications, if you pay the applicable Co-insurance payment for each month supplied after the deductible has been met.

NOTE: CVS Caremark offers two ways to obtain up to a 90-day supply of maintenance drugs:

1. You can use a Retail Network Pharmacy; or,
2. You can use the CVS Caremark Mail Order.

Note: Pharmacy benefits apply only if your prescription is for a Covered Health Service, and not for experimental, investigational or unproven services. Otherwise, you are responsible for paying 100% of the cost.

Your Co-insurance is determined by the Prescription Drug List (PDL). All Prescription Drug Products on the PDL are assigned to Tier 1, Tier 2 or Tier 3. To determine tier status, view the PDL at info.caremark.com/shbp, or call the CVS Caremark Customer Care number on your UnitedHealthcare Member ID Card.

Note: Prescription Co-insurance does apply to the Deductible and the Member's Out-of-Pocket Maximum. Co-insurance payments will not be overridden or changed on an individual basis.

Coverage for up to a 31-day supply for a participating Retail Network Pharmacy:

Tier 1: 30% Co-insurance after Deductible is met

Tier 2: 30% Co-insurance after Deductible is met

Tier 3: 30% Co-insurance after Deductible is met

Coverage for up to 31-day supply from a Retail Non-Network Pharmacy

In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network pharmacy. If the Out-of-Network pharmacy you use bills more than the Plan would reimburse for that same drug to a network pharmacy under their contracted rates after you have met the deductible, then you must pay the difference in cost plus your Co-insurance as outlined for a participating retail pharmacy above. The same supply limits exist for non-network prescriptions as those described above for in-network prescriptions.

Specialty Prescription Drug Products

For Benefits provided for outpatient Specialty Prescription Drug Products, the following apply:

- As written by a Physician up to a 31-day supply; or
- Up to a 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits established for a particular drug by the plan
- When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a 31-day supply, the Co-insurance that applies will reflect the number of days dispensed.

Specialty Coverage for up to a 31-day supply:

Tier 1: 30% Co-insurance after Deductible is met

Tier 2: 30% Co-insurance after Deductible is met

Tier 3: 30% Co-insurance after Deductible is met

Prescription Drug Products from CVS Caremark Mail Order

The following supply limits apply for Benefits for outpatient Prescription Drug Products dispensed by the CVS Caremark Mail Order:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits established for a particular drug by the plan.
- Your doctor must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills).

To fill the prescription, you may:

- Mail your prescription(s) along with the required form to CVS Caremark Mail Order
- Ask your Doctor to call (844) 345-3241 for instructions on how to fax the prescription. Your Doctor must include your UnitedHealthcare Member ID number.
- Order through the CVS Caremark website after you register at info.caremark.com/shbp.
- Drop off your prescription at your local CVS Retail Pharmacy who will have your prescription filled through the mail order coverage.

Coverage up to a consecutive 90-day supply through Mail Order:

Tier 1: 30% Co-insurance after Deductible is met for up to a 90-day supply
Tier 2: 30% Co-insurance after Deductible is met for up to a 90-day supply
Tier 3: 30% Co-insurance after Deductible is met for up to a 90-day supply

What Is Not Covered – Prescription Drug Exclusions

Exclusions from coverage listed in the SPD apply also to this Rider. In addition, the following prescription drug exclusions apply:

1. Prescriptions that have been prescribed based solely on electronic patient questionnaires or by any other means where there is no proper relationship between the practitioner and patient.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.
3. Drugs that are dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.
4. Experimental, Investigational or Unproven Services and medications; medications and/or indications not approved by the Food and Drug Administration (FDA) used for experimental indications and/or dosage regimens determined by CVS Caremark to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. Some injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by CVS Caremark, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to flu, Gardasil, and Zostavax vaccines, self-administered injectable medications, select physician administered injectable medications and Specialty medications covered through your Pharmacy Benefit Plan.
9. The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
14. Prescription Drug Products when prescribed to treat infertility.
15. Compound drugs which contain any non-covered ingredients and compounds which do not contain at least one ingredient that requires a prescription. Compound drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available pharmaceutical product. Other coverage rules may apply.
16. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, and folic acid – that require a prescription for coverage.
17. Yohimbine.
18. Mifeprex.
19. Blood or blood plasma products except for hemophilia factors.
20. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.
21. Nutritional supplements, except for those specifically identified as included under the plan. Contact CVS Caremark for a list of covered supplements.
22. Any Prescription Drug Product that is therapeutically equivalent to an OTC drug on CVS Caremark's OTC equivalent list. Prescription Drug Products that compromise components that are available in OTC form or an equivalent.
23. Certain drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs) such as; Jublia, Absorica, Nascobal, Kerydin, Zipsor, Aplenzin, Sitavig, Xerese, and Zyflo. Please note that changes to this list can be made quarterly.

Frequently Asked Questions- Prescription Drug

This section will help you understand your medication choices and make informed decisions, plus it will help you understand which questions to ask your Doctor or Pharmacist.

Q1: Does this mean I can only go to CVS Pharmacy® for my prescriptions?
A1: Members do NOT have to go to CVS Pharmacy for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their covered dependent(s) can continue to use local retail and/ or chain pharmacies to obtain their prescription medications. Use CVS Caremark's pharmacy locator tool to find a network pharmacy near you. See the following questions for specialty medications.

Q2: Where can I go for more information?
A2: Visit the CVS Caremark website at info.caremark.com/shbp or call:

CVS Caremark Customer Care	(844) 345-3241
CVS Specialty®:	(866) 845-6786
CVS Prior Authorization for Physicians	(866) 231-6377
CVS Prior Authorization for Specialty Drugs	(866) 231-8371

Q3: What is a preferred drug list?
A3: The CVS Caremark preferred drug list for the State Health Benefit Plan (SHBP) is a list of U.S. Food and Drug Administration (FDA)-approved prescription drugs developed by CVS Caremark to provide coverage for SHBP members. You may pay more out of pocket under your plan for non-preferred drugs (those not listed as preferred on the preferred drug list) than you would for preferred drugs (those listed as preferred on the preferred drug list).

Q4: How do I use my preferred drug list and what are tiers?
A4: Your preferred drug list has different levels of payment, or tiers, for preferred and non-preferred medicines. You may pay:

$	Tier 1	Generic drugs and some select Brand-name drugs
$$	Tier 2	Preferred drugs, mostly Brand-name drugs
$$$	Tier 3	Non-preferred drugs, mostly Brand-name drugs

Your doctor may be able to help you save money by prescribing Generic and preferred Brand-name drugs, if appropriate, on the preferred drug list. So be sure to bring a copy of the abbreviated preferred drug list with you on every visit to your doctor. You can print a copy of the abbreviated preferred drug list from info.caremark.com/shbp. **Please note:** The list does not contain a complete list of preferred and non-referred drugs. It only lists the most commonly prescribed drugs. For more information, visit info.caremark.com/shbp to check the price and coverage of medications under your plan. You can also call CVS Caremark Customer Care at 844-345-3241.

Q5: Will the 2022 preferred drug list be different from the current preferred drug list that I have now?
A5: Yes. Effective January 1, 2022, your plan's preferred drug list (sometimes called a formulary) will have changes. As a result, some preferred medications may become non-preferred, and vice versa. With CVS Caremark, "Tier 1" will include all Generic drugs and some select Brand-name drugs, "Tier 2" will include all preferred drugs, which are mostly Brand-name drugs, and "Tier 3" will include all non-preferred drugs, which is mostly Brand-name drugs. It's important to note that some medications may move from one tier to another. Depending on whether the medication is moving to a higher or lower tier, the amount you pay for that medication may increase or decrease. Visit info.caremark.com/shbp to view your new preferred drug list and find out which medications are preferred. If you are taking a drug that is about to become non-preferred, you may want to talk to your doctor about a lower-cost option.

Q6: Will the preferred drug list ever change?
A6: CVS Caremark makes updates to its preferred drug list on an ongoing basis. Changes can be made to the preferred drug list on a quarterly basis.

Q7: Will I be informed if my drug changes status on the drug list?
A7: Yes. CVS Caremark will mail a notification letter to you if your drug changes tier status and results in a higher Co-insurance cost to you at any point during the year.

Q8: Are any drugs excluded from my preferred drug list?
A8: The only prescription drugs excluded from your preferred drug list are drugs that fall under coverage areas which are not covered by your benefit design; such as drugs used for cosmetic purposes, drugs for weight loss, or drugs covered under the medical benefit through your medical claims administrator. Please refer to your Summary Plan Document (SPD) for additional information about non-covered drugs.

Q9: What is a 90-day retail pharmacy, and how can I find out if the pharmacy I go to is in that 90-day retail network?
A9: Getting up to a 90-day supply at a retail pharmacy is a feature of your prescription benefit, managed by CVS Caremark. With it, you have two ways to get up to a 90-day supply of your maintenance medicine (a medicine you take on an ongoing basis). You can conveniently fill those prescriptions either through CVS Caremark Mail Service Pharmacy™ or at a participating 90-day retail pharmacy. The 90-day retail network is a smaller collection of network pharmacies which are willing to provide a 90-day supply of your maintenance medications at a discounted rate to our members. To locate one, visit info.caremark.com/shbp. You can also locate participating pharmacies by calling CVS Caremark at (844) 345-3241. You can use a retail network pharmacy that isn't in the 90-day network to get your 90-day supply of maintenance medications too, but your Co-insurance may be higher than what you would pay if you used one of the pharmacies in the 90-day retail network.

Q10: How do I start using CVS Caremark Mail Service Pharmacy?
A10: You can choose one of four easy ways:

- Phone: Call Customer Care at (844) 345-3241.
- Online: Visit info.caremark.com/shbp to register and sign in. Follow the guided steps to request a prescription. Once we have your information, we will contact your doctor for a 90-day prescription of your current medicine.
- Fax: Prescriber can fax a mail service order form to 1 (800) 378-0323.
- Mail: Fill out and return a mail service order form. You can download one at info.caremark.com/shbp, or you can obtain one from Customer Care at (844) 345-3241.

Q11: Which medications can I fill through the CVS Caremark Mail Service Pharmacy?
A11: Mail service is a convenient way to have 90-day supplies of your long-term medications shipped to you at no added cost. Mail service can save you both time and money—you don't have to worry about making a trip to the pharmacy every 31 days, and 90-day supplies typically cost less than three 31-day supplies. For more information, call CVS Caremark Customer Care.

Q12: Can I get a 90-day supply of my long-term medications at retail or at CVS Caremark mail order?
A12: Yes.

Q13: Where do I register for CVS Caremark pharmacy services?
A13: Go to info.caremark.com/shbp.

Q14: How long does it take to receive my medications that I order through CVS Caremark mail service?
A14: For new prescriptions, it can take up to 10 days from the day you submit your order for delivery of your medication. Refills are usually delivered within seven days of placing your order. Although CVS Caremark processes the orders within a day or two, the exact delivery day is dependent on the U.S. Postal Service.

Q15: Is there an additional charge for shipping and handling?
A15: No. Medications are shipped by standard service at no cost to you. Express shipping is also available for an additional fee.

Q16: How can I check the status of my refill order?
A16: You can check the status of your mail order refill for traditional medications by signing on to Caremark.com. Click "My Account" on the top right of the page, then click "Prescription History and Order Status." You can also call the CVS Caremark Customer Care at (844) 345-3241.

Q17: Will I be reminded when it's time to refill?
A17: Yes. You can sign up for refill reminders in one of three ways:

- Go online to info.caremark.com/shbp.
- Use the CVS Caremark mobile app.
- Call CVS Caremark Customer Care at (844) 345-3241.

Q18: How can I check that my current pharmacy is in the CVS Caremark Retail Pharmacy Network?
A18: You can visit info.caremark.com/shbp. You can also call CVS Caremark Customer Care at (844) 345-3241.

Q19: How can I find out how much my cost is going to be?
A19: You can find out the cost of your drugs by visiting info.caremark.com/shbp or by calling the CVS Caremark Customer Care at (844) 345-3241.

Q20: What if I want to speak with a pharmacist?
A20: You can speak to a pharmacist 24 hours a day, seven days a week, by calling the CVS Caremark Customer Care at (844) 345-3241. When you call, you may be asked several questions to verify your identification.

Q21: What can I do on the CVS Caremark website?
A21: You may access the CVS Caremark website from a link on the SHBP website www.shbp.ga.gov or go to info.caremark.com/shbp to get information about your plan, find participating retail pharmacies near you and see how much certain medicines will cost. You can go to info.caremark.com/shbp to also quickly refill mail service prescriptions, receive timely medication alerts, find potential lower-cost options available under your plan, check order status and ask questions of a pharmacist online. In order to get information specifically about your SHBP plan, you'll need to register first. Have your new UnitedHealthcare Member ID card handy when you sign up.

Q22: How do I download the CVS Caremark mobile app?
A22: Visit your smartphone's or tablet's market or store and search for "CVS Caremark." It's free to download and use.

Q23: What is a prior authorization (PA)?
A23: Prior authorization is administered by CVS Caremark to determine whether your use of certain medications meets your plan's conditions of coverage. In some cases, a prior authorization may be necessary to determine whether a prescription can be covered under your plan. If your prescription requires prior authorization, your doctor can initiate the prior authorization review by calling the CVS Caremark Customer Care at (866) 231-6377. CVS Caremark will inform you and your doctor in writing of the outcome.

Q24: Can I find out ahead of time if a medication may need a prior authorization?
A24: Yes. Go to info.caremark.com/shbp and check the cost of your drug. By checking the cost of your drug, you will also be informed of whether a prior authorization or any other requirements are needed for your medication. You may also check the Preferred Drug List posted on the website for your drug which shows any edits required.

Q25: What is a specialty pharmacy?
A25: A specialty pharmacy provides injectable, oral and infused medicines. These complex and costly medicines usually require special storage and handling and may not be readily available at a local pharmacy. Sometimes these medications have side effects that require monitoring by a trained pharmacist or nurse. CVS Specialty focuses on providing these medicines while offering excellent customer service and clinical support to you and your caregivers.

Q26: Why should I use CVS Specialty for my specialty medicines?
A26: As you may know, the cost of prescription drugs has been rising dramatically over the last several years. That's especially true of specialty medicines. By using CVS Specialty for specialty drugs, your prescription drug benefit can offset some of these high costs.

Q27: How do I get started with CVS Specialty?
A27: You can call us at (866) 845-6786 and we will help get you started. With your permission, we will fax your doctor to request a new prescription. Or, your doctor can initiate this by sending CVS Caremark your prescription electronically, by fax or by phone. After your doctor provides the prescription to CVS Caremark, one of our patient care representatives will call you to arrange a convenient time to deliver your medicine. CVS Specialty will provide an expected delivery time after CVS Caremark receives the prescription from your doctor and all shipping requirements are met. CVS Caremark uses scheduled delivery service companies at no cost to you, and all packages include most of the supplies you'll need to properly administer your medicines, also at no charge.

Q28: How much medicine can I receive per specialty prescription?
A28: You may receive up to a 31-day supply at a time of specialty medicine through CVS Specialty.

Q29: What if I have questions about my specialty medications?
A29: Visit www.cvsspecialty.com anytime or call CVS Specialty at (866) 845-6786 to speak with a representative. At CVS Specialty, you have access to a team of pharmacists and nurses.

Q30: Is there an extra cost to use CVS Specialty services?
A30: No. CVS Specialty is part of your prescription drug benefit.

Q31: Can I order all my medications from CVS Specialty?
A31: No. CVS Specialty dispenses only specialty medicines. Any other non-specialty prescriptions sent to CVS Specialty will be transferred to CVS Caremark mail service.

Prescription Drug Glossary and Definitions

This section defines the terms used throughout this Outpatient Prescription Drug Rider.

Ancillary Charge: A charge that, in addition to the Co-insurance, you are required to pay if a covered Brand-name Prescription Drug Product is dispensed at you or your physician's request, when a chemically equivalent generic Prescription Drug Product is available. The Ancillary Charge is calculated as the difference between the cost of the Brand-name Prescription Drug Product and cost of the Generic Prescription Drug Product, based on CVS Caremark retail network rates.

Brand-name: A Prescription Drug Product that: (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) CVS Caremark identifies as a Brand-name product based on available data resources – including, but not limited to, Medispan– that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as "Brand-name" by the manufacturer, Pharmacy or your Physician may not be classified as Brand- name by CVS Caremark.

Covered Person: Either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this chapter are references to a Covered Person.

Co-Insurance: A percentage of the total cost of the claim that must be paid by the Member.

Designated Pharmacy: A pharmacy that has entered into an agreement with CVS Caremark, or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Full Retail Cost: Also known as Usual and Customary Charges. This is the amount that a Pharmacist would charge a cash-paying customer for a prescription.

Generic: A Prescription Drug Product that: (1) is chemically equivalent to a Brand-name drug; or (2) CVS Caremark identifies as a Generic product based on available data resources – including, but not limited to, Medispan – that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as a "Generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by CVS Caremark.

Mail Order: Allows members requiring maintenance medications the convenience of having maintenance medications delivered to the home or office by US mail, a common carrier or a delivery service.

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

Network Pharmacy: A pharmacy that has:

- Entered into an agreement with CVS Caremark or its designee to provide Prescription Drug Products to Covered Persons
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products
- Been designated by CVS Caremark as a Network Pharmacy

A Network Pharmacy can be a participating Retail, Home Delivery or Specialty Designated Pharmacy.

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Plan's Pharmacy Claims Administrator's Prescription Drug List Management Committee, or
- December 31st of the following plan year

Prescription Drug Cost: The rate CVS Caremark has contracted with the Network Pharmacies on behalf of SHBP, including a dispensing fee and any sales tax, if applicable, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL): A PDL is a list of FDA-approved Brand-name and Generic medications. The PDL is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

Prescription Drug Product: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver or a skilled caregiver in the case of certain Specialty medications. For the purpose of Benefits under the plan, this definition includes but is notlimited to:

- Inhalers (with spacers)
- Insulin

The following diabetic supplies:

- Insulin syringes with or without needles
- Urine/Blood Test Strips & Tapes
- Lancets
- Blood Glucose Testing monitors
- Continuous Glucose Monitor/Transmitters/Sensors

Preventive Care Medications: The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-insurance) as required by applicable law under any of the following:

- with respect to infants, children and adolescents, evidence- informed preventive care provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

You may determine whether a drug is a Preventive Care Medication at info.caremark.com/shbp or by calling the CVS Caremark Customer Care at the toll-free telephone number on your UnitedHealthcare Member ID card.

Specialty Prescription Drug Product: A Prescription Drug Product that is generally a high-cost, oral or self-injectable biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs at info.caremark.com/shbp or by calling CVS Customer Care at the number on your UnitedHealthcare Member ID card.

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

End of Pharmacy Benefits Administrator

Legal Notices 2022

About the Following Notices

The following important legal notices are also posted on the State Health Benefit Plan (SHBP) website at www.shbp.georgia.gov under Plan Documents:

Penalties for Misrepresentation
If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP participants for fraud (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

To avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician
The Plan generally allows the designation of a Primary Care Physician/Provider (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family members. For children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCP's, call the telephone number on the back of your Identification Card. Access to Obstetrical and Gynecological (OB/GYN) Care You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) Care
You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

HIPAA Special Enrollment Notice
If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly

eligible dependent child).

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:
- The Covered Person's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call SHBP Member Services at 1-800-610-1863 or visit the SHBP Enrollment Portal: www.mySHBPga.adp.com.

Women's Health and Cancer Rights Act of 1998
The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other medical and surgical benefits under your Plan Option. Following cancer surgery, the SHBP covers:
- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy
- Treatment of physical complications of mastectomy, including lymphedema

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification. For more detailed information on the mastectomy-related benefits available under your Plan option, call the telephone number on the back of your Identification Card.

Newborns' and Mothers' Health Protection Act of 1996
The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES
Georgia Department of Community Health
State Health Benefit Plan Notice of Information Privacy Practices

The purpose of this notice is to describe how medical information about you, which includes your personal information, may be used and disclosed and how you can get access to this information. Please review it carefully.

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy. DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" (PHI), and includes any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. This notice tells how your PHI is used and shared by DCH and Plan Representatives. DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Only Summary Information is Used When Developing and/or Modifying the Plan.
The Board of Community Health, which is the governing Board of DCH, the Commissioner of DCH and the Chief of the Plan administer the Plan and make certain decisions about the Plan. During those processes, they may review certain reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any individual person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DCH may provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information may only be used by your employer to obtain health insurance quotes from other sources and make decisions about whether to continue to offer the Plan. Please note that DCH, Plan Representatives, and your employer are prohibited by law from using any PHI that includes genetic information for underwriting purposes.

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information, "Enrollment Information" and "Claims Information". "Enrollment Information" includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment.

"Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

Your PHI is Protected by HIPAA. Under HIPAA, employees of DCH and employees of outside companies and other vendors hired or contracted either directly or indirectly by DCH to administer the Plan are "Plan Representatives," and therefore must protect your PHI. These Plan Representatives may only use PHI and share it as allowed by HIPAA, and pursuant to their "Business Associate" agreements with DCH to ensure compliance with HIPAA and DCH requirements.

DCH Must Ensure the Plan Complies with HIPAA. DCH must make sure the Plan complies with all applicable laws, including HIPAA. DCH and/or the Plan must provide this notice, follow its terms and update it as needed. Under HIPAA, Plan Representatives may only use and share PHI as allowed by law. If there is a breach of your PHI, DCH must notify you of the breach.

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI.

HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing.

Claims Administrator Companies: Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers.

Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan; and communicate with the Plan Members and/or their health care providers.

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan.

State of Georgia Attorney General's Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan.

Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI.

Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.

NOTE: Treatment is not provided by the Plan but we may use or disclose PHI in arranging or approving treatment with providers.

Under HIPAA, all employees of DCH must protect PHI and all employees must receive and comply with DCH HIPAA privacy training. Only those DCH employees designated by DCH as Plan Representatives for the SHBP health care component are allowed to use and share your PHI.

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations. HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following:

Compliance with a Law or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law or to prevent a serious threat to health and safety.

Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities.

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies, as applicable, that may provide you or your dependents benefits (such as state retirement systems or other state or federal programs) in order to get information about your or your dependent's eligibility for the Plan, to improve administration of the Plan, or to facilitate your receipt of other benefits.

Research Purposes: Your PHI may be given to researchers for a research project, when the research has been approved by an institutional review board. The institutional review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you and/or with your legal personal representative. However, the Plan may provide limited information to the employee about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. Plan Representatives may not use or share your PHI for any reason that is not described in this notice without a written authorization by you or your legal representative. For example, use of your PHI for marketing purposes or uses or disclosures that would constitute a sale of PHI are illegal without this written authorization. If you give a written authorization, you may revoke it later.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You. Right to Inspect and Obtain a Copy of your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or incomplete,

you may contact the Plan to request a correction.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures.

Right to Ask for a Restriction of Uses and Disclosures or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety.

Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Member Services Center at 1-800- 610-1863 or you may download a copy at www.shbp.georgia.gov. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Addresses to File HIPAA Complaints:
Georgia Department of Community Health
SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

U.S. Department of Health & Human Services
Office for Civil Rights
Region IV
Atlanta Federal Center
61 Forsyth Street SW
Suite 3B70
Atlanta, GA 30303-8909
1-877-696-6775

For more information about this Notice, contact:
Georgia Department of Community Health
State Health Benefit Plan
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

Summaries of Benefits and Coverage
Summaries of benefits and coverage describe each Plan Option in the standard format required by the Affordable Care Act. These documents are posted here: https://shbp.georgia.gov/plan-documents. To request a paper copy, please contact SHBP Member Services at 800-610-1863.

Georgia Law Section 33-30-13 Notice:
SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 0% higher than it would be if the Affordable Care Act provisions did not apply.