

Summary Plan Description

MISSISSIPPI VALLEY INTERGOVERNMENTAL COOPERATIVE HEALTH BENEFIT PLAN

Effective: July 1, 2016

Alton Community Unit School District #11

Group Number: 705787

Including School Districts and Related Entities:

Alton Community Unit School District #11 (Group 705787)
Cahokia Community Unit School District #187 (Group 705776)
Calhoun Community Unit School District #40 (Group 705778)
Collinsville Community Unit School District #10 (Group 709076)
Columbia Community Unit School District #4 (Group 705779)
Edwardsville Community Unit School District #7 (Group 705781)
Granite City Community Unit School District #9 Group 705782)
Madison Community Unit School District #12 (Group 705783)
MISSVIC Administrative Offices (Group 705785)
Roxana Community Unit School District #1 (Group 709833)
Venice Community Unit School District #3 (Group 705786)



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SECTION 1 - WELCOME

Quick Reference Box

- For member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator refer to the number on the back of the UnitedHealthcare medical ID card;
- Claims submittal address: UnitedHealthcare - Claims, PO Box 30432, Salt Lake City, UT 84130-0432; and
- Online assistance: www.myuhc.com.

Alton Community Unit School District #11 is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

Alton Community Unit School District #11 intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Alton Community Unit School District #11 is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- 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.
- You can request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Alton Community Unit School District #11 is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

If at the time of your hire, Alton Community Unit School District #11 reasonably expects you to be a regular full-time employee who has at least 30 hours of service per week, you will be eligible for health coverage on your date of hire.

In addition, you will be eligible if under the terms of any Collective Bargaining Agreement between the School and your Union, the terms of Eligibility differ from those outlined here. In that case, the eligibility terms under the Collective Bargaining Agreement will be incorporated into this document by reference. You will be notified of your eligibility if eligibility terms differ under any Collective Bargaining Agreement between the School and your Union.

If at the time of hire, Alton Community Unit School District #11 reasonably expects you to be a variable hour employee or seasonal employee, your hours will be measured over 12 months starting with the first of the month following your date of hire (**“initial measurement period”**). During this time, you are not eligible for benefits; however, you may be entitled to certain subsidies under the Exchange Marketplace to purchase (www.healthcare.gov). At the end of the initial measurement period, Alton Community Unit School District #11 will determine whether you averaged 30 or more hours of service per week during the initial measurement period. This period is called the **“initial administrative period”** and it will last 60 days. If you averaged 30 or more hours of service during the initial measurement period, Alton Community Unit School District #11 will allow you an opportunity to enroll in benefits. If you did not average 30 or more hours of service during the initial measurement period, you will not be eligible for benefits, subject to any potential employment status changes and the rules for ongoing employees, below. Your benefits eligibility, whether you are benefits eligible or not, will remain locked-in during the immediately following 12 months (**“initial stability period”**) so long as you remain an active employee with Alton Community Unit School District #11.

Notwithstanding the above, if Alton Community Unit School District #11 has designated you as a variable hour or seasonal employee, your ongoing benefits eligibility will be determined over 12 months beginning every May 1st and ending every April 30th (**“standard measurement period”**). Beginning with the next standard measurement period following your date of hire, Alton Community Unit School District #11 will measure your hours of service to determine whether you averaged at least 30 hours of service or more per

week. Immediately following the standard measurement period, Alton Community Unit School District #11 will undertake a “**standard administrative period**”, which will run from May 1st to June 30th of each year. During the standard administrative period, Alton Community Unit School District #11 will notify you of your potential benefits eligibility and allow you an opportunity to enroll in benefits. If you were found to have averaged at least 30 or more hours of service per week during the standard measurement period, you will be eligible to enroll in benefits, and if you timely enroll in benefits, your eligibility will be “locked in” for the 12-month period immediately following the standard administrative period (July 1st to June 30th of each year). This is called the “**standard stability period.**” If you were not found to have averaged 30 or more hours of service per week during the standard measurement period, you will not be benefits eligible during the standard stability period. However, on an ongoing basis, your hours of service will be measured over the course of subsequent standard measurement periods each year to determine whether you qualify for benefits eligibility for a standard stability period.

Newly hired employees in the initial measurement period will also have an opportunity to qualify for benefits during the standard measurement period immediately following their date of hire.

When assessing eligibility under the initial or standard measurement periods for instructional employees, those employees will not be prejudiced by any period of four weeks or more that the employee is not working as an instructional employee due to any periods of time instructional employees are typically not in instructional positions during a measurement period (for example, an instructional employee will not be prejudiced by having zero work hours during the school summer break).

Retiree Eligibility

An employee who retires while covered under this Plan may continue coverage under this Plan for him or herself and any Dependents covered under the Plan as of the date of retirement. Unless otherwise legally required, only Dependents that are participants as of the date of retirement who were covered under the Plan may continue such coverage. The retiree must be covered for any Dependents to be covered. Coverage will continue provided the retiree makes timely premium contributions if so required. If coverage ceases due to nonpayment of premium, at the election of the retiree, or because the School District no longer offers retiree coverage, the retiree’s coverage and all dependent coverage will terminate. Once terminated, retiree coverage may not be reinstated unless legally required.

A retiree may elect to continue coverage under COBRA as an alternative to continuing coverage under this Plan pursuant to this retiree eligibility provision. If the retiree continues coverage pursuant to this retiree eligibility provision, unless legally required, neither the retiree nor his or her Dependents will be offered COBRA coverage upon termination of coverage under this Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, Glossary;

- you or your Spouse's child who is under age 26 regardless of marital status, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Any unmarried dependent child under 30 if the Dependent:

- Is an Illinois resident;
- Served as active or reserve member of an U.S. Armed Forces, and
- Received release or discharge other than dishonorable discharge.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

To be eligible for this, the Dependent must submit to us a form approved by the Illinois Department of Veteran's Affairs stating the date on which the dependent was released from service.

Dependent Child covered to age 26 regardless of student status and up to age 30 if a veteran as outlined above.

Coverage terminates at the end of the month in which the dependent attains the maximum age.

Contact Human Resources for more information on benefit eligibility rules, including return-to-work eligibility rules and employment status change policies.

Cost of Coverage

You and Alton Community Unit School District #11 share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Alton Community Unit School District #11 reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, Human Resources call within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following July 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date Human Resources receives notice of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

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

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

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;

- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the

placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Alton Community Unit School District #11's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Alton Community Unit School District #11's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant 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. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

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.

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 Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

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. Use www.myuhc.com to search for Physicians available in your Plan.

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. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Alton Community Unit School District #11 or UnitedHealthcare.

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

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

Alton Community Unit School District #11 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 UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, 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. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

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

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

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - 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:
 - ◆ For Covered Health Services other than pharmaceutical products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ When Covered Health Services are pharmaceutical products, 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.

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

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card

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

Annual Deductible

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

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.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

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

Coinsurance

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

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. 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 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?
Medical Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

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. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

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 and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **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 toll-free number on your ID card.

Requirements for Notifying Personal Health Support

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified.

The services that require Personal Health Support notification are:

- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Congenital Heart Disease services;
- dental services - accident only;
- dental services – anesthesia and facility charges;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent;
- Genetic Testing – BRCA
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay – all elective admissions;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; and
- transplantation services.

When you choose to receive services from non-Network providers, UnitedHealthcare urges you to confirm with Personal Health Support that the services you plan to receive are Covered Health Services. That's 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; or
- any other limitation or exclusion of the Plan.

For notification timeframes, and reductions in Benefits that apply if you do not notify Personal Health Support, see Section 6, *Additional Coverage Details*.

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

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

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

Plan Features	Network	Non-Network
<p>Copays¹</p> <ul style="list-style-type: none"> ■ Emergency Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services - Primary Physician ■ Physician's Office Services - Specialist ■ Urgent Care Center Services 	<p>\$250</p> <p>\$100</p> <p>\$25</p> <p>\$50</p> <p>\$25</p>	<p>\$250</p> <p>Not Applicable</p> <p>Not Applicable</p> <p>Not Applicable</p> <p>Not Applicable</p>
<p>Annual Deductible²</p> <ul style="list-style-type: none"> ■ Individual ■ Family (not to exceed \$1,000 per Covered Person for Network Benefits and not to exceed \$2,000 per Covered Person for Non-Network Benefits) 	<p>\$750</p> <p>\$1,500</p>	<p>\$1,000</p> <p>\$2,000</p>
<p>Annual Out-of-Pocket Maximum²</p> <ul style="list-style-type: none"> ■ Individual ■ Family (not to exceed \$4,000 per Covered Person for Network Benefits and not to exceed \$8,000 per Covered Person for Non-Network Benefits) 	<p>\$3,000</p> <p>\$6,000</p>	<p>\$4,000</p> <p>\$8,000</p>
<p>Lifetime Maximum Benefit⁵</p> <p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p>	<p>Unlimited</p>	

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

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

⁵Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Ambulance Services - Emergency Only	<i>Ground Transportation</i> 100%	<i>Ground Transportation</i> Same as Network
	<i>Air Transportation</i> 100%	<i>Air Transportation</i> Same as Network
Cancer Resource Services (CRS)² ■ Hospital - Inpatient Stay (Copay is per admission)	90% after you pay a \$100 Copay and after you meet the Annual Deductible	Not Covered
Clinical Trials - Routine Patient Care Costs Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Dental Services - Accident Only	100% after you pay a \$25 Copay	Same as Network
Dental Services – Anesthesia and Facility Charges	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.	

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p>Diabetes Services</p> <p>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</p> <p>Diabetes Self-Management Items</p> <ul style="list-style-type: none"> ■ diabetes equipment ■ diabetes supplies <p>See <i>Durable Medical Equipment</i> in Section 6, <i>Additional Coverage Details</i>, for limits</p>	<p>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.</p> <p>Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.</p>	
<p>Durable Medical Equipment (DME)</p> <p>See Section 6, <i>Additional Coverage Details</i> for limits.</p>	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
<p>Emergency Health Services</p> <p>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.</p>	100% after you pay a \$250 Copay	
<p>Eye Examinations</p> <p>See Section 6, <i>Additional Coverage Details</i>, for limits</p>	100% after you pay a \$25 Copay	70% after you meet the Annual Deductible
<p>Hearing Aids</p>	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
<p>Home Health Care</p>	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Hospice Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay (Copay is per admission)	90% after you pay a \$100 Copay and after you meet the Annual Deductible	70% after you meet the Annual Deductible
Injections received in a Physician's Office	\$3 per injection, then 100%, except for immunizations	70% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	90% after you meet the Annual Deductible	Not Covered
Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	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.	
Mental Health Services		
<ul style="list-style-type: none"> ■ Inpatient 	90% after you pay a \$100 Copay and after you meet the Annual Deductible	70% after you meet the Annual Deductible
<ul style="list-style-type: none"> ■ Outpatient 	100% after you pay a \$25 Copay	70% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Neurobiological Disorders - Autism Spectrum Disorder Services <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient 	<p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>100% after you pay a \$25 Copay</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>
Nutrition	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery <ul style="list-style-type: none"> ■ Physician's Office Services (Copay is per visit) ■ Professional Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay (Copay is per admission) ■ Outpatient Surgery 	<p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>100% after you pay a \$25 Copay</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> ■ Outpatient Diagnostic Services ■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine ■ Outpatient Therapeutic Treatments <p>See Section 6, <i>Additional Coverage Details</i> for limits</p>	<p>100%</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>
Ostomy Supplies	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
<p>Outpatient Surgery, Diagnostic and Therapeutic Services</p> <ul style="list-style-type: none"> ■ Outpatient Surgery ■ Outpatient Diagnostic Services <ul style="list-style-type: none"> - Preventive Lab and radiology/X-ray - Preventive mammography testing - Sickness and Injury related diagnostic services ■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine 	<p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>100%</p> <p>100%</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> ■ Outpatient Therapeutic Treatments 	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pediatric Dental Under Medical	100% of billed charge	100% of billed charge
<p>Physician's Office Services - Sickness and Injury</p> <p>No Copayment applies when a Physician charge is not assessed.</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay per visit) ■ Specialist Physician (Copay per visit) 	<p>100% after you pay a \$25 Copay</p> <p>100% after you pay a \$50 Copay</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>
<p>Preventive Care Services</p> <ul style="list-style-type: none"> ■ Physician Office Services ■ Outpatient Diagnostic Services ■ Breast Pumps 	<p>100%</p> <p>100%</p> <p>100%</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Prosthetic Devices	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Reconstructive Procedures		
<ul style="list-style-type: none"> ■ Physician's Office Services (Copay is per visit) ■ Hospital - Inpatient Stay (Copay is per admission) ■ Professional Fees for Surgical and Medical Services ■ Prosthetic Devices ■ Outpatient Surgery ■ Outpatient Diagnostic Services ■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine ■ Outpatient Therapeutic Treatments 	<p>100% after you pay a \$25 Copay</p> <p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>100%</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p>	<p>70% after you meet the Annual Deductible</p> <p>70% and after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% and after you meet the Annual Deductible</p> <p>70% and after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>
<p>Rehabilitation Services - Outpatient</p> <p>(Copay is per visit)</p> <p>See Section 6, Additional Coverage Details, for visit limits.</p>	<p>100% after you pay a \$25 Copay</p>	<p>70% after you meet the Annual Deductible</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>(Copay is per admission)</p> <p>Up to 90 days per calendar year</p>	<p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.</p>	<p>70% after you meet the Annual Deductible</p>
<p>Spinal Treatment</p> <p>Up to 15 days per calendar year</p>	<p>70% not subject to the Annual Deductible</p>	<p>50% not subject to the Annual Deductible</p>
<p>Substance Use Disorder Services</p> <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient 	<p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p> <p>100% after you pay a \$25 Copay</p>	<p>70% after you meet the Annual Deductible</p> <p>70% after you meet the Annual Deductible</p>
<p>Temporomandibular Joint Dysfunction (TMJ)</p> <p>Up to \$2,500 during the entire period you are covered under the Plan.</p>	<p>90% after you meet the Annual Deductible</p>	<p>70% after you meet the Annual Deductible</p>
<p>Transplantation Services</p> <p>(If services rendered by a Designated Facility)</p>	<p>90% after you pay a \$100 Copay and after you meet the Annual Deductible</p>	<p>Not Covered</p>

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Urgent Care Center Services (Copay is per visit)	100% after you pay a \$25 Copay	Same as Network
Virtual Visits 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 telephone number on your ID card.	100% after you pay a \$20 Copay	Non-Network Benefits are not available.
Wigs	100%	100%

¹You must notify Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, 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 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. 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 8, *Exclusions*.

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

Cancer Resource Services (CRS)

United Healthcare will arrange for access to certain of its Network providers participating in the Cancer Resource Services Program for the provision of oncology services. You may be referred to Cancer Resource Services by United Healthcare, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive Benefits under this program, Cancer Resource Services 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.

When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the described in Section 5, *Plan Highlights* under the headings *Physician's Office Services – Sickness and Injury*, *Professional Fees for Surgical and Medical Services*, *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services* listed in this section.

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 notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials – - Routine Patient Care Costs

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

- 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; or
 - 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*; and
 - ◆ 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; or
 - 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.

Dental Services - Accident Only

Coverage is provided for Dental services when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.";
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

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

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

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

- started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.
- completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

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

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Personal Health Support can determine whether the service is a Covered Health Service.

Dental Services – Anesthesia and Facility

Coverage is provided for general anesthesia and hospital charges for dental services if patient is:

- A child under age 6,
- Severely disabled; or
- Has a medical or behavioral condition that requires a hospital setting.

Please remember for Non-Network Benefits, you must notify Personal Health Support. If Personal Health Support is not notified, Benefits will be subject to a \$500 reduction.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	<p>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.</p> <p>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.</p>
Diabetic Self-Management Items	<p>Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:</p> <ul style="list-style-type: none"> ■ blood glucose monitors; ■ insulin syringes with needles; ■ blood glucose and urine test strips; ■ ketone test strips and tablets; and ■ lancets and lancet devices. <p>Insulin pumps are subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i> in this section.</p> <p>Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under <i>Durable Medical Equipment</i> in this section.</p>

Please remember for Non-Network Benefits, you must notify Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than \$1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable; and
- not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage;
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage);
- Foot orthotics.

Please remember for Non-Network Benefits, you must notify Personal Health Support if the purchase, rental, repair or replacement of DME will cost more than \$1,000. If Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Emergency Health Services - Outpatient

The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within two business days 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 not available for services to treat a condition that does not meet the definition of an Emergency.

Please remember for Non-Network Benefits, you must notify Personal Health Support within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be subject to a \$500 reduction.

Eye Examinations

The Plan pays Benefits for eye examinations received from a health care provider in the provider's office.

Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year under the medical Plan.

Benefits are provided under Spectera for one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year. Contact Spectera for additional information regarding Benefits.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses by a Non-Network Provider. The Plan does not include Benefits provided by a Non-Network provider for routine vision exams, including refraction to detect vision impairment.

Hearing Aids

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

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only 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.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services or as soon as reasonably possible. If Personal Health Support is not notified, Benefits will be subject to a \$500 reduction.

Hospice Care

The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Any combination of Network Benefits and Non-Network Benefits is limited to 180 days per Covered Person during the entire period you are covered under the Plan.

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services. If Personal Health Support is not notified, Benefits will be subject to a \$500 reduction.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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 Therapeutics*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you must notify Personal Health Support as follows:

- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): within one business day or the same day of admission, or as soon as is reasonably possible.

If Personal Health Support is not notified, Benefits will be subject to a \$500 reduction.

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Kidney Resource Services (KRS)

UnitedHealthcare will arrange for access to certain of its Network Providers participating in the Kidney Resource Services Program for End Stage Renal Disease (ESRD) and chronic kidney disease. You may be referred to KRS by UnitedHealthcare, or you may self refer to KRS by calling 888-936-7246 and select the KRS prompt. In order to receive the highest level of Benefits, you must contact KRS prior to obtaining Covered Health Services. The services include Covered Health Services and supplies rendered for the treatment and/or diagnosis relating to ESRD or chronic kidney disease.

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.

When these services are not performed in a KRS facility, Benefits will be paid the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services listed in this section.

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

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.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 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.

Please remember for Non-Network Benefits, you must notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Personal Health Support is not notified, Benefits for the extended stay will be subject to a \$500 reduction.

Mental Health Services

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

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive inpatient Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a \$500 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and

- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

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

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive inpatient Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a \$500 reduction.

Nutrition

Amino Acid-Based Elemental Formulas

Coverage for the diagnosis and treatment of:

- Eosinophilic disorders;
- Short bowel syndrome when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

- Enteral formula, nutritional supplements and low protein modified food products.

For purposes of this benefit, the following definitions apply:

- "Eosinophilic disorders" mean digestive disorders where eosinophils (a type of white blood cell) are found in above normal amounts in one or more areas of the digestive tract. They can be on the esophagus, stomach, and both large and small intestines and if left untreated may cause poor growth or malnutrition.
- "Acid-based elemental formulas" mean a special liquid type nutritional product made up of amino acids which are the building block of proteins and typically more tolerable.
- "Low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Benefits should be recommended by a physician for the treatment of cystic fibrosis, pancreatic insufficiency, phenylketonuria or any inherited disease of amino and organic acids.

Obesity Surgery

Services are provided for the surgical treatment of morbid obesity when the method of surgery is recognized by the National Institute of Health as an effective method for long-term reversal of morbid obesity.

Services include, but are not limited to the following:

- Gastric bypass
- Roux-en-Y gastric bypass
- Gastric banding
- Vertical Banded Gastroplasty (VBG)

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and catheters; and

- skin barriers.

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

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

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

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab and radiology/X-ray.
- Mammography testing.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

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

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Therapeutic Treatments

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

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

Pediatric Dental under Medical

Preventive pediatric dental is covered for Dependents 18 and under as follows:

- 2 oral exams per calendar year;
- 2 cleanings per calendar year;
- 2 fluoride treatments per calendar year;
- 2 sealants per calendar year; and
- 1 set of x-rays per calendar year.

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.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

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

Please remember for Non-Network Benefits you must notify the Claims Administrator for Genetic Testing – BRCA. If notification is not provided as required, Benefits will be reduced by \$500 by Eligible Expenses.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Preventive Care Services

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

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

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 6, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

Benefits are only available if breast pumps are obtained from a DME provider or physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Professional Fees for Surgical and Medical Services

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

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

Prosthetic Devices

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

- Artificial arms, legs, feet and hands.

- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits are also provided for wigs that are required as a result of cancer. Benefits for wigs are limited to \$300 per lifetime.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

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

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

Reconstructive Procedures

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

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated 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 Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Please remember that for Non-Network Benefits you must notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

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

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Benefits 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.

Habilitative Services

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, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

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

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.

For purposes of this benefit, “habilitative services” means health care services that help a person keep, learn or improve skills and functioning for daily living.

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.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke Autism Spectrum Disorder or a Congenital Anomaly.

Benefits are limited to:

- 60 visits per calendar year for physical therapy;
- 60 visits per calendar year for occupational therapy;
- 60 visits per calendar year for speech therapy;
- 60 visits per calendar year for pulmonary rehabilitation therapy; and
- 60 visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Any combination of Network Benefits and Non-Network Benefits is limited to 90 days per calendar year.

Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

Please remember for Non-Network Benefits, you must notify Personal Health Support as follows:

- for elective admissions: five business days before admission;
- for non-elective admission: within one business day or the same day of admission; and
- for Emergency admissions: as soon as is reasonably possible.

If Personal Health Support is not notified, Benefits will be subject to a \$500 reduction.

Spinal Treatment

Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 15 visits per calendar year.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator 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 the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a \$500 reduction.

Temporomandibular Joint (TMJ) Services

The Plan pays for Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits are not available for charges or services that are dental in nature.

Any combination of Network Benefits and Non-Network Benefits is limited to \$2,500 per Covered Person during the entire period you are covered under the Plan.

Transplantation Services

Covered Health Services for organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

Notification is required for all transplant services.

Examples of transplants for which Benefits are available include but are not limited to:

- bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility.

- heart transplants;
- heart/lung transplants;
- lung transplants;
- kidney transplants;
- kidney/pancreas transplants;
- liver transplants;
- liver/small bowel transplants;
- pancreas transplants; and
- small bowel transplants.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient and a companion are available under this Plan 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 transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum Benefit of \$10,000 per Covered Person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

Please remember that you must notify United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Personal Health Support is not notified and if, as a result, the services are not performed at a Designated Facility, no Benefits will be paid and you will be responsible for paying all charges.

Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment 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 going to www.myuhc.com or by calling the telephone number on your ID card.

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

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Wigs

Coverage for Wigs/Toupees, will be excluded except for:

Wigs/Toupees in event of chemotherapy, alopecia, or permanent loss of hair due to accidental injury. There is a \$300 annual maximum and a 3 wig lifetime maximum.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Alton Community Unit School District #11 believes in giving you the tools you need to be an educated health care consumer. To that end, Alton Community Unit School District #11 has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

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

NOTE:

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 and Alton Community Unit School District #11 are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You and your Spouse are invited to learn more about your health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to www.myuhc.com. After logging in, access your personalized *Health & Wellness*. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Alton Community Unit School District #11's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM 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 Alton Community Unit School District #11 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.

NurseLineSM 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.

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

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

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, 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.

Note: If you have a medical emergency, call 911 instead of logging onto www.myuhc.com.

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;
- coronary disease and
- bariatric surgery.

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

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM 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 PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** 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;

- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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 as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

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

Want to learn more about a condition or treatment?

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

Disease and Condition Management Services

Disease Management Services

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

These programs offer:

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

- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - 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 the back of your ID card.

HealthNotesSM

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;

- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please 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 and acupuncture;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing;
6. other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;
4. guest service;

5. supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - air conditioners;
 - air purifiers and filter;
 - batteries and battery chargers;
 - dehumidifiers;
 - humidifiers.
 - devices and computers to assist in communication and speech.

Dental

1. dental care, except as described in Section 6, *Additional Coverage Details* under the heading *Dental Services - Accident only*.
2. preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - extraction, restoration and replacement of teeth;
 - medical or surgical treatments of dental conditions;
 - services to improve dental clinical outcomes.
3. dental implants.
4. dental braces.
5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - transplant preparation;
 - initiation of immunosuppressives;
 - the direct treatment of acute traumatic Injury, cancer or cleft palate.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

This exclusion also 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, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

Drugs

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

2. self-injectable medications;
3. non-injectable medications given in a Physician's office except as required in an Emergency; and
4. over the counter drugs and treatments.

Experimental or Investigational Services or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

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 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:
 - cutting or removal of corns and calluses;
 - nail trimming or cutting; and
 - debriding (removal of dead skin or underlying tissue);
2. hygienic and preventive maintenance foot care. Examples include the following:
 - cleaning and soaking the feet;
 - applying skin creams in order to maintain skin tone;
 - other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
3. treatment of flat feet; and
4. treatment of subluxation of the foot.

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies. Examples include:
 - diabetic test strips; and
 - diabetic supplies (syringes and lancets).
3. orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to any orthotic braces available over-the-counter.

4. cranial banding and some types of braces; and
5. tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 6, *Additional Coverage Details* under the heading *Durable Medical Equipment*.

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
 - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
 - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; and
 - not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorder or condition based on generally accepted standards of medical practice and benchmarks;
 -
3. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, sexual dysfunctions, communication disorders, motor disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
12. gambling disorders;
13. substance-induced sexual dysfunction disorders and substance-induced sleep disorders; and
12. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. megavitamin and nutrition based therapy;
2. nutritional counseling for either individuals or groups, except as specifically described in Section 6, *Additional Coverage Details*;
3. enteral feedings 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). Infant formula available over the counter is always excluded; and
4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:
 - pharmacological regimens, nutritional procedures or treatments;
 - scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - skin abrasion procedures performed as a treatment for acne;
2. replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered

reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;

3. physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;
4. weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded; and
5. wigs regardless of the reason for the hair loss except for temporary loss of hair resulting from treatment of a malignancy except for chemotherapy, alopecia, or permanent loss of hair due to accidental injury, in which case the Plan pays up to a maximum of \$300 per Covered Person per lifetime.

Providers

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

This exclusion does not apply to mammography testing.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility;

2. surrogate parenting, donor eggs, donor sperm and host uterus;
3. storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue;
4. the reversal of voluntary sterilization;
5. health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination.

This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage);

6. Fetal reduction surgery; and
7. health services associated with the use of non-surgical or drug-induced Pregnancy termination.

Services Provided under Another Plan

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

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

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

Transplants

1. health services for organ, multiple organ and tissue transplants, except as described in *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);
3. health services for transplants involving mechanical or animal organs;
4. Transplant services that are not performed at a Designated Facility; and
5. any solid organ transplant that is performed as a treatment for cancer.

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services;
2. travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Vision

1. purchase cost of eye glasses or contact lenses;
2. fitting charge for eye glasses or contact lenses;
3. eye exercise or vision therapy; and
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

1. health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*;

This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;

2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when;
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
 - related to judicial or administrative proceedings or orders;
 - conducted for purposes of medical research; and
 - required to obtain or maintain a license of any type.
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
4. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
5. health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
6. in the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or the Annual Deductible are waived;
7. charges in excess of Eligible Expenses or in excess of any specified limitation;
8. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature;
9. non-surgical treatment of obesity, including morbid obesity;
10. growth hormone therapy;

11. sex transformation operations;
12. Custodial Care;
13. domiciliary care;
14. private duty nursing;
15. respite care;
16. rest cures;
17. psychosurgery;
18. treatment of benign gynecomastia (abnormal breast enlargement in males);
19. medical and surgical treatment of excessive sweating (hyperhidrosis);
20. panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
21. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
22. oral appliances for snoring;
23. speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly;
24. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
25. any charge for services, supplies or equipment advertised by the provider as free; and
26. any charges prohibited by federal anti-kickback or self-referral statutes.

SECTION 9 - CLAIMS PROCEDURES

What 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, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

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

If Your Provider Does Not File Your Claim

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

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;

- the date the Sickness or Injury began; and
- 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.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

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.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, MISSVIC Administrative Offices reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes MISSVIC Administrative Offices pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- the provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where

Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month, in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

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

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

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

- the patient's name and ID number as shown on the ID card;

- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- 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, Utah 84130-0432

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

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.

Review of an Appeal

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.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

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.

Federal External Review Program

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

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

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

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

An external review request should include all of the following:

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

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

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

Standard External Review

You may request an external review in writing within 4 months after receipt of a notice of adverse or final adverse determination.

UnitedHealthcare will complete a preliminary review of the external review request within 5 business days of receipt to determine whether:

- You were a Covered Person at the time services were requested or provided;
- The services are a Covered Health Service, but UnitedHealthcare had decided they did not meet our requirements for, appropriateness, health care setting, level of care, or effectiveness;
- You have exhausted the required internal grievance process;
- In the case of Experimental or Investigational Services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your Physician; and
- You have submitted all required information and forms.

Within 1 business day after completing the preliminary review, UnitedHealthcare will provide written notice to you indicating whether the request is complete and eligible for external review. If incomplete, UnitedHealthcare will notify you of any missing information needed to complete the request. If ineligible, UnitedHealthcare will explain the reasons for ineligibility for external review and notify you that you may appeal our decision to the Department of Insurance. The Director is authorized to reverse our initial determination and require that the request be referred for external review.

If eligible for external review, within 5 business days, UnitedHealthcare will:

- Assign an independent review organization from the Director's list of approved independent review organizations qualified to conduct an external review; and
- Notify you in writing of the request's eligibility and the name of the assigned independent review organization. The notice must also include a statement that you may, within 5 business days of the notice receipt, submit in writing to the assigned independent review organization any additional information to be considered by the independent review organization in the review. (The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days).

Within 5 business days of assigning an approved independent review organization, UnitedHealthcare will send the independent review organization any documents and information considered in making the adverse determination. If UnitedHealthcare fails to do so, the independent review organization may terminate the external review and reverse the adverse or final adverse determination in which case the independent review organization must notify UnitedHealthcare and you within 1 business day.

In addition to any documents and information provided by UnitedHealthcare and you, an independent review organization shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the independent review organization's clinical reviewer.

The independent review organization must provide written notice of its decision to UnitedHealthcare and you within 5 business days after receiving all necessary information.

- The independent review organization notice must include a general description of the reason for the external review request, the date it was assigned, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, and the principal reason(s) for its decision.
- For experimental or investigational treatment reviews, the independent review organization notice must also include descriptions of the factors considered by the independent review organization in making its decision.

An independent review organization is not bound by any decisions or conclusions reached in our utilization review, internal grievance or appeals process.

Expedited External Review

You or your authorized representative may request, orally or in writing, an expedited external review:

After receiving a notice of adverse determination from UnitedHealthcare if:

- Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or standard external review; or
- The adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.

After receiving a notice of final adverse determination from UnitedHealthcare if:

- Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for a standard external review;
- The final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received Emergency Health Services but have not been discharged from the facility; or
- The final adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.

- UnitedHealthcare fails to provide a decision on an expedited internal appeal within 48 hours.

UnitedHealthcare will determine whether the request meets the following reviewability requirements:

- You were a Covered Person at the time services were requested or provided;
- The services are a Covered Health Service, but UnitedHealthcare decided they did not meet the requirements for appropriateness, health care setting, level of care, or effectiveness; and
- In the case of Experimental or Investigational Services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your Physician.

UnitedHealthcare will notify you of our eligibility determination.

If determined ineligible for expedited external review, UnitedHealthcare will also notify you that you may appeal our decision to the Director of Insurance.

If eligible for expedited external review, UnitedHealthcare will:

- Assign an independent review organization from the Director's list of approved independent review organization qualified to conduct external review;
- Provide or transmit (electronically, by telephone, facsimile or any other available expeditious method) to the assigned independent review organization all necessary documents and information considered in making the final adverse determination. UnitedHealthcare will provide this information to the independent review organization within 24 hours after assigning the independent review organization. If UnitedHealthcare fails to do so, the independent review organization may terminate the external review and reverse the adverse or final adverse determination in which case the independent review organization must notify UnitedHealthcare and you within 1 business day.

In addition to any documents and information provided by UnitedHealthcare and you, an independent review organization shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the independent review organization's clinical reviewer.

The independent review organization must reach a decision and notify UnitedHealthcare and you within 2 business days after receiving all necessary information.

The independent review organization is not bound by any decisions or conclusions reached in our utilization review or internal grievance process.

Within 48 hours of rendering its decision, the independent review organization must provide written confirmation of its decision to UnitedHealthcare and you. The confirmation must include the following information:

- A general description of the reason for the external review request, the date it was assigned, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, and the principal reason(s) for its decision.
- For experimental or investigational treatment reviews, descriptions of the factors considered by the independent review organization in making its decision.

Expedited external review is prohibited for retrospective adverse or final adverse determinations.

Independent Review Organization

All decisions by the independent review organization are deemed as binding on UnitedHealthcare, and on you to the extent that you have other remedies available under applicable federal or state law.

UnitedHealthcare will approve coverage if the independent review organization reverses the final adverse decision.

If an independent external review decision upholds an adverse determination, you may appeal the independent review organization's decision to the Department of Insurance until July 1, 2015. Appeals to the Department of Insurance Statements informing you and any authorized representative that a standard external review (or Expedited External Review) request deemed to be ineligible for review by us or our representative may be appealed to the Director by filing a complaint with the Department of Insurance. To appeal initial determinations of ineligibility for standard external review (or Expedited External Review) please contact:

Illinois Department of Insurance
Office of Consumer Health Insurance
Standard External Review (or Expedited External Review)
320 West Washington Street
Springfield, IL 62767
http://insurance.illinois.gov/Complaints/file_complaint.asp (E-mail)
Toll Free Telephone: (877)527-9431

Until July 1, 2015 if an external independent review decision upholds a determination that is adverse to you, you have the right to appeal the independent review organization's final decision to the Department of Insurance. To appeal the independent review organization's final decision to the Department please contact:

Illinois Department of Insurance
Office of Consumer Health Insurance
Illinois Health Carrier External Review - Director Appeals
320 West Washington Street
Springfield, IL 62767
http://insurance.illinois.gov/Complaints/file_complaint.asp (E-mail)
Toll Free Telephone: (877)527-9431

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, as defined in Section 14, *Glossary*;
- 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.

The tables below 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
If UnitedHealthcare needs more information from your Physician to make a decision, UnitedHealthcare will notify you orally of the decision within 24 hours following receipt of the required information. Written notice will be sent following oral notification.	
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
A formal decision will be made within 15 business days after receipt of all required information. You will be notified orally of the decision and written notice will be sent following oral notification.	
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
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:	

Post-Service Claims	
Type of Claim or Appeal	Timing
■ 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 Alton Community Unit School District #11 or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Alton Community Unit School District #11 or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Alton Community Unit School District #11 or the Claims Administrator.

You cannot bring any legal action against Alton Community Unit School District #11 or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Alton Community Unit School District #11 or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Alton Community Unit School District #11 or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

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

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

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

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

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;

- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare*.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare– typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

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

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

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

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

Refund of Overpayments

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

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

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, 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 makes 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 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 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement.

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

Subrogation – Example

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

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

Reimbursement – Example

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

The following persons and entities are considered third parties:

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

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - providing any relevant information requested by the Plan;
 - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
 - responding to requests for information about any accident or injuries;
 - making court appearances;
 - obtaining the Plan’s consent or its agents’ consent before releasing any party from liability or payment of medical expenses; and
 - complying with the terms of this section.
- Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys’ fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys’ fees, shall be deducted from the Plan’s recovery without the Plan’s express written consent. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal

representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan 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; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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

When your coverage ends, Alton Community Unit School District #11 will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date UnitedHealthcare receives written notice from Alton Community Unit School District #11 to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date UnitedHealthcare receives written notice from Alton Community Unit School District #11 to end your coverage, or the date requested in the notice, if later; or
- the date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to Alton Community Unit School District #11's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: Alton Community Unit School District #11 has the right to demand that you pay back Benefits Alton Community Unit School District #11 paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Alton Community Unit School District #11 proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Alton Community Unit School District #11's request that the child continues to meet these conditions.

The proof might include medical examinations at Alton Community Unit School District #11's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

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

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Alton Community Unit School District #11 is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

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

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Alton Community Unit School District #11 files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or

- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

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

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

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or

- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Alton Community Unit School District #11;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Alton Community Unit School District #11

In order to make choices about your health care coverage and treatment, Alton Community Unit School District #11 believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Alton Community Unit School District #11 and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Alton Community Unit School District #11 and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Alton Community Unit School District #11 and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Alton Community Unit School District #11 and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Alton Community Unit School District #11, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Alton Community Unit School District #11's agents or employees, nor are they agents or employees of UnitedHealthcare. Alton Community Unit School District #11 and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employee's agents or employees of Network providers.

Alton Community Unit School District #11 and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Alton Community Unit School District #11 and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Alton Community Unit School District #11 's employees nor are they employees of UnitedHealthcare. Alton Community Unit School District #11 and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Alton Community Unit School District #11 and UnitedHealthcare are not liable for any act or omission of any provider.

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

Alton Community Unit School District #11 is solely responsible for:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

Alton Community Unit School District #11 and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Alton Community Unit School District #11 and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Alton Community Unit School District #11 may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Alton Community Unit School District #11 does so in any particular case shall not in any way be deemed to require Alton Community Unit School District #11 to do so in other similar cases.

Information and Records

Alton Community Unit School District #11 and 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. Alton Community Unit School District #11 and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Alton Community Unit

School District #11 and UnitedHealthcare will keep this information confidential. Alton Community Unit School District #11 and 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 Alton Community Unit School District #11 and UnitedHealthcare with all information or copies of records relating to the services provided to you. Alton Community Unit School District #11 and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Alton Community Unit School District #11 and UnitedHealthcare agree that such information and records will be considered confidential.

Alton Community Unit School District #11 and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Alton Community Unit School District #11 is required to do by law or regulation. During and after the term of the Plan, Alton Community Unit School District #11 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 Alton Community Unit School District #11 recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, Alton Community Unit School District #11 and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The

Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Alton Community Unit School District #11 recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Alton Community Unit School District #11 and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Alton Community Unit School District #11 and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

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

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

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

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

An Alternate Facility may also provide Mental Health or Substance Use 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.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

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

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

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

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Alton Community Unit School District #11. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants 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.

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain 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.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Alton Community Unit School District #11.

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

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

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

Covered Health Services – those health services, including services or supplies, which UnitedHealthcare determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant 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.

CRS – see Cancer Resource Services (CRS).

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

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

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

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

DME – see Durable Medical Equipment (DME).

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 UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

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

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

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

- arises suddenly; and

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

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

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Alton Community Unit School District #11.

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 6, *Additional Coverage Details*.

If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Alton Community Unit School District #11. The KRS program provides:

- specialized consulting services to Participants 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.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by Alton Community Unit School District #11 who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with 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.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by Alton Community Unit School District #11, during which eligible Participants may enroll themselves and their Dependents under the Plan. Alton Community Unit School District #11 determines the period of time that is the Open Enrollment period.

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. See Section 3, *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.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

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.

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

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. 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 Alton Community Unit School District #11 Medical Plan.

Plan Administrator – Alton Community Unit School District #11 or its designee.

Plan Sponsor – Alton Community Unit School District #11 .

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

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

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

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

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

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

- it is established and operated in accordance with applicable state law for residential treatment programs;

- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

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

Retired Employee – an Employee who retires while covered under the Plan.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

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

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

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.

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

Spouse – an individual to whom you are legally married.

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

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

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

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM 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 ProgramSM 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.

Please note:

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

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

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

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

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

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan 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.

Additional Plan Description

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

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

The Claims Administrator 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. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is Alton Community Unit School District #11, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II – LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).

PRESCRIPTION DRUG BENEFITS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Benefits.

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan other than the Alton Community School District #11. Any pre-existing provisions of this plan do not apply to Prescription Drug Benefits.

Identification Card (I.D. Card) – Network Pharmacy

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

If You don't show Your ID card or provide verifiable information at a Network Pharmacy, You will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered a Covered Expense.

The Plan pays benefits at different levels for tier 1, tier 2 and tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Formulary. The tier status of a Prescription Drug can change periodically, as frequently as monthly, based on the Express Scripts Pharmacy and Therapeutics (P & T) Committee periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the Formulary may change periodically, for the most current information, You can visit www.express-scripts.com or call the Customer Service number on Your Express Scripts' I.D. Card.

Each tier is assigned a Co-pay or Participation, which is the amount You pay when You visit the pharmacy or order Your medications through mail order. Your Co-pay or Participation will also depend on whether or not You visit the pharmacy or use the mail order service; see the Prescription Schedule of Benefits for further details. Here's how the tier system works:

- Tier 1 is Your lowest Co-pay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

- Tier 2 is Your middle Co-pay or Participation option. Consider a tier 2 drug if no tier 1 drug is available to treat Your condition.
- Tier 3 is Your highest Co-pay or Participation option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

For Prescription Drugs at a retail Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Charge that Express Scripts agreed to pay the Network Pharmacy. For Prescription Drugs from a mail order Network Pharmacy, You are responsible for paying the lower of:
 - The applicable Co-pay, Participation or Deductible amount; or
 - The Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by visiting www.express-scripts.com or by calling the Customer Service number on Your Express Scripts' I.D. card.

To obtain Your Prescription from a retail pharmacy, simply present Your ID card and pay the Co-pay, Participation or Deductible amount. The Plan pays benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

Note: Pharmacy Benefits apply only if Your prescription is for a Covered Expense, and not for Experimental, Investigational, or Unproven Services. Otherwise, You are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow You to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic Illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all You need to do is complete a patient profile and enclose Your Prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after Your order is received. If You need a patient profile form, or if You have any questions, You can call the Customer Service number on Your Express Scripts' I.D. card.

The Plan pays mail order benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

It is recommended that if You need Your Prescription Drug order immediately, you fill Your Prescription Drug order at the retail pharmacy first and then call the Customer Service number on Your Express Script's I.D. card to have Your Prescription moved to mail order.

Note: To maximize Your benefit, ask Your Physician to write Your Prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-pay, Participation, or Deductible amount for any Prescription order or refill if You use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure Your Physician writes Your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Designated Pharmacy

If You require certain Prescription Drugs, Express Scripts may direct You to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see the Definitions in this section for the definition of Designated Pharmacy.

Want to lower Your out-of-pocket Prescription Drug costs?

Consider tier 1 Prescription Drugs, if You and Your Physician decide they are appropriate.

Assigning Prescription Drugs to the Formulary

The P&T Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the P&T Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or notification requirements should apply.

Economic factors may include:

- The acquisition cost of the Prescription Drug; and
- Available rebates and assessments on the cost effectiveness of the Prescription Drug.

When considering a Prescription Drug for tier placement, the P&T Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The P&T Committee may periodically change the placement of a Prescription Drug among the tiers. These changes may occur as frequently as monthly and may occur without prior notice to You.

Prescription Drug, Formulary and P&T Committee are defined at the end of this section.

Formulary

The Formulary is a tool that helps guide You and Your Physician in choosing the medications that allow the most effective and affordable use of Your Prescription Drug benefit.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist, or You to obtain prior authorization. Express Scripts will determine if the Prescription Drug, in accordance with Your plan's approved guidelines, is:

- A Covered Expense as defined by the Plan; and
- Not Experimental, Investigational, or Unproven.
- A Prescription Drug not being used for off-label use.

The Plan may also require You to obtain a prior authorization so Express Scripts can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Physician.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or You are responsible for obtaining prior authorization from Express Scripts.

To determine if a Prescription Drug requires prior authorization, You can visit www.express-scripts.com or call the Customer Service number on Your Express Scripts' I.D. card. The Prescription Drugs requiring prior authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after Express Scripts reviews the documentation provided and determines that the Prescription Drug is not a covered health service or it is an Experimental, Investigational, or Unproven service.

The Plan may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.express-scripts.com or call the Customer Service number on Your Express Scripts' I.D. card.

Limitation on Selection of Pharmacies

If Express Scripts determines that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, You may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the designated single Network Pharmacy.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per Prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.express-scripts.com or call the Customer Service Number on Your Express Scripts' I.D. card. Whether or not a Prescription Drug has a supply limit is subject to Express Scripts' periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan and Express Scripts have developed, subject to 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.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, Your Co-pay, Participation, or Deductible amount may change. You will pay the amount applicable for the tier to which the Prescription Drug is assigned.

Special Programs

Alton Community School District #11 and Express Scripts 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 through the Internet at www.express-scripts.com or call the Customer Service number on Your Express Scripts' I.D. card.

Rebates and Other Discounts

Express Scripts and Alton Community School District #11 may, at times, receive rebates for certain drugs on the Formulary. Express Scripts does not pass these rebates and other discounts on to You, nor does Express Scripts take them into account when determining Your Co-pays.

Express Scripts and a number of its affiliated entities conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants, and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. Express Scripts is not required to pass on to You, and does not pass on to You, such amounts.

Covered Benefits - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

Prescription products which are:

- Necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed medical professional; and
- Can be obtained only by Prescription and are dispensed in a container labeled “Rx only”; and
- The following non-prescription products prescribed by a duly licensed medical professional:
 - Compounded medications of which at least one ingredient is a Prescription Drug;
 - Any other medications which due to state law may only be dispensed when prescribed by a duly licensed medical professional; and
 - In an amount not to exceed the day’s supply outlined in the Prescription Schedule of Benefits.
- **Prescription Drugs lost or damaged.** Covered Persons can call the Customer Service number on Your Express Scripts’ I.D. card and explain the situation to the Express Scripts’ representative. Express Scripts will follow the appropriate internal process to determine whether or not they will refund/replace the Prescription Drug(s).
- **Mail Order Prescriptions.** The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the mail order pharmacy identified by Express Scripts. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Schedule of Benefits (refer to Prescription Drug Benefits Schedule noted at the end of the Prescription Drug section). By law, Prescription products cannot be mailed to a Covered Person outside the United States.

Covered Expenses apply to only certain Prescription Drugs and supplies. You can visit www.express-scripts.com or call the Customer Service number on Your Express Scripts’ I.D. card for information on which specific Prescription Drugs and supplies are covered.

Exclusions - What the Prescription Benefits Section of this Plan Will Not Cover

In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.express-scripts.com or call the Customer Service number on Your Express Scripts’ I.D. card for information on which Prescription Drugs are excluded.

The Prescription Drug Program will not provide benefits for any of the drugs or supplies listed in this section, regardless of the prescription of a Physician. The list includes, but is not limited to the following specifically excluded drugs:

- All infertility drugs.
- Drugs for cosmetic uses, except as stated above.
- Photo-aged skin products (example: Renova).
- Hair growth agents (example: Propecia, Vaniqa).

- Depigmentation products.
- Contraceptive methods with the exception of the following:
 - Barrier contraceptive method – diaphragms/cervical caps
 - Hormonal contraceptive methods, oral, transdermal, intravaginal Injectable Hormonal contraceptive
 - Emergency contraceptive method RX and OTC – e.g. Plan B and Ella
 - Implantable medications – e.g. Implanon
 - Intrauterine contraceptives – e.g. Mirena, Skyla
 - OTC contraceptive devices - e.g. non-spermicidal condom
 - OTC contraceptive medications – e.g. anything with a spermicide
- Impotence injectables or Yohimbine
- Drugs used for weight loss or appetite suppression.
- Serums, toxoids and/or vaccines.
- Allergens.
- Smoking Cessation products (example: Zyban, Chantix).
- Over-the-counter (OTC) drugs and drugs with OTC equivalents, except insulin and covered diabetic supplies.
- Medical Foods.
- Durable Medical Equipment, Peak Flow Meters, Ostomy supplies.
- Non-FDA approved drugs, dosages or indications/uses.
- Experimental/investigational drugs.
- Therapeutic devices or appliances, support garments and other non-medical substances.
- Drugs intended for use in a physician's office or another setting other than home use.
- Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
- Certain compound drugs.

Definitions

Brand-name means a Prescription Drug that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- Identified by Express Scripts as a Brand-name drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-name by Express Scripts.

Participation means the percentage of the cost You are required to pay for certain Prescription Drugs.

Co-payment (or Co-pay) means the set dollar amount You are required to pay for certain Prescription Drugs.

Designated Pharmacy means a pharmacy that has entered into an agreement with Express Scripts, or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Formulary means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.express-scripts.com or calling the Customer Service number on Your Express Scripts' I.D. card.

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by Express Scripts as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as "Generic" by the manufacturer, pharmacy, or Your Physician may not be classified as Generic by Express Scripts.

Network Pharmacy means a retail or mail order pharmacy that has:

- Entered into an agreement with Express Scripts to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by Express Scripts as a Network Pharmacy.

Pharmacy and Therapeutics P&T Committee means the committee that Express Scripts designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Prescription Drug means a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a Prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs also include:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
 - Insulin syringes with needles;
 - Blood-testing strips - glucose;
 - Urine-testing strips - glucose;
 - Ketone-testing strips and tablets;
 - Lancets and lancet devices;
 - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - Glucose monitors.

Prescription Drug Charge means the rate Express Scripts has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Therapeutic Class means a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent means when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge, also known as the retail price, means the amount charged to customers who have no health coverage for Prescription Drugs.

Prescription Drug Schedule of Benefits

	Retail Network Pharmacy For up to a 31 day supply	Home Delivery Network Pharmacy For up to a 90 day supply
Tier 1 (Generics)	\$10	\$20
Tier 2 (Preferred)	\$30	\$50
Tier 3 (Non Preferred)	\$50	\$80
Fertility Drugs	Not Covered	Not Covered

Annual Drug Deductible: No Annual Drug Deductible

Out-of-Pocket Drug Maximum: Individual \$3,000/Family \$6,000

You are responsible for paying 100% of the cost (the amount the pharmacy charges You) for any non-covered drug product and contracted rates (Prescription Drug Cost) will not be available to You.

