Certificate of Coverage For Employees and Eligible Dependents of

Benefithelp, Inc.

03HQ

September 01, 2012

through

August 31, 2013

Enrolled in

UnitedHealthcare Insurance Company of the River Valley

WELCOME

Welcome to UnitedHealthcare Insurance Company of the River Valley. The following Certificate of Coverage, with its attachments and amendments, explains your healthplan benefits. Please read this information carefully and keep it for future reference.

When your coverage became effective, you should have received your ID cards, which lists your coverage codes and any dependents covered under your plan. If there are any changes in your family status or address, or if you obtain other health benefit coverage, please notify your Personnel Office.

If you need a list of participating providers, or if you have any questions, please call Customer Service at the telephone number on your ID card.

Thank you for joining UnitedHealthcare Insurance Company of the River Valley.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer (or enrolling group) must provide you with at least a 30 day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer or group health plan administrator for more information.

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and benefits stated in the Certificate of Coverage (Certificate) and Attachment D (Schedule of Benefits). A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  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.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the *PPACA* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans*.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA,* the *Public Health Service Act,* and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
  - 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*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under PPACA that may also impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.
  - If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or

UnitedHealthcare for more information on the appeal rights available to you under your plan. (Also, please refer to the Claims and Appeal Notice section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or Explanation of Benefits that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits.*

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. They will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Patient Protection and Affordable Care Act (PPACA) Preventive Care Medications Addendum

UnitedHealthcare Insurance Company of the River Valley

As described in this addendum, benefits for Preventive Care Medications described in the drug rider are modified as stated below.

Because this addendum is part of a legal document (the Group Health Contract), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* and in this addendum below.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley. When we use the words "you" and "your," we are referring to people who are Subscribers, as that term is defined in the *Certificate*.

Benefits for Preventive Care Medications

Benefits under the drug rider include those for Preventive Care Medications as defined below. You may determine whether a drug is a Preventive Care Medication through the internet at www.uhcrivervalley.com or by calling *Customer Service* at the telephone number on your ID card.

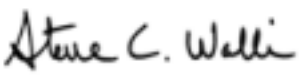
Defined Terms

The following definition of Preventive Care Medications is added to the drug rider:

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Fill, Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any otherwise applicable Drug Copayment, Drug Coinsurance, Drug Deductible, Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- 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*.
- 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.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication through the internet at www.uhcrivervalley.com or by calling Custo*mer Service* at the telephone number on your ID card.



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Steve C. Walli, President

BIRTH CONTROL EXCLUSION
Amendment

UnitedHealthcare Insurance Company of the River Valley

As described in this Amendment, the Certificate of Coverage is modified to remove the birth control exclusion.

The following exclusion in the Certificate of Coverage under the section ***Exclusions Applicable to the Contract,*** is removed and the remainder of the section would be renumbered:

8.21 Drugs, medicines, or any implants or devices used in conjunction with birth control regardless of the intended use unless provided in a supplemental benefits rider attached hereto.

Health Resources and Services Administration (HRSA) Amendment

UnitedHealthcare Insurance Company of the River Valley

As described in this Amendment, the Contract is modified as stated below.

Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Because this Amendment is part of a legal document (the Group Health Contract), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Article 1: Definitions*.

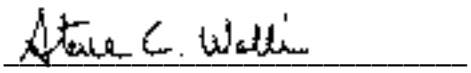
When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley. When we use the words "you" and "your," we are referring to people who are Subscribers, as that term is defined in *Article I: Definitions*.

Benefits for Breast Pumps

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. Network benefits for preventive care are payable at 100% of Allowed Charges (without application of any Copayment, Coinsurance, or Deductible).

If more than one breast pump can meet your needs, benefits are available only for the most cost effective pump. We 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.



Steve C. Walli, President

THIS CONTRACT
PROVIDES FOR COMPREHENSIVE
HEALTH CARE TO THE EXTENT HEREIN
LIMITED AND DEFINED

Issued By

UnitedHealthcare Insurance Company of the River Valley

A Corporation Certified Under the Applicable Laws
of the State of Operation

CERTIFICATE OF COVERAGE
UNDER GROUP HEALTH CONTRACT

This Contract between the Subscriber who has enrolled and UnitedHealthcare Insurance Company of the River Valley ("UnitedHealthcare") is part of the Group Health Contract between UnitedHealthcare and Group through which the Member has enrolled. The Group Health Contract and this Contract, as defined in Article 1, form the entire contract.

This Contract entitles the Subscriber and Eligible Dependents to receive the benefits set forth herein during the Contract Period, subject to the terms and conditions of this Contract and upon payment of the Premium.

UnitedHealthcare Insurance Company of the River Valley
1300 River Drive, Suite 200
Moline, Illinois 61265

By:_____
President

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ARTICLE 1 – DEFINITIONS

1.1 **Allowed Charge** – the portion of a charge for a Covered Service that UnitedHealthcare will consider in calculating benefits. The Allowed Charge is determined as follows:

1.1.1 **Participating Provider.** For Covered Services received from a Participating Provider, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract.

1.1.2 **Non-Participating Provider – Medical Emergency.** For Covered Services received from a Non-Participating Provider due to a Medical Emergency, the Allowed Charge is the Maximum Allowance. If the Billed Charge exceeds the Maximum Allowance, the Member is not responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance.

1.1.3 **Non-Participating Provider – Non-Emergency.** For non-emergency Covered Services received from a Non-Participating Provider, the Allowed Charge is the Maximum Allowance. If the Billed Charge exceeds the Maximum Allowance, the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance.

1.2 **Appeal** – a complaint which, having been reported by the Member and remaining unresolved to the Member's satisfaction, is filed for formal proceedings as set forth in Article 17.

1.3 **Attending Physician** – a Physician who is primarily responsible for the care of Members with respect to any particular injury or illness.

1.4 **Billed Charge** – the amount a Provider bills for any services and supplies, whether or not the services or supplies are covered under this Contract. The Billed Charge may be different from the amount that UnitedHealthcare determines to be the Allowed Charge.

1.5 **Coinsurance** – a percentage of the Allowed Charge that the Member must pay for Covered Services received. The percentage is shown in Attachment D.

1.6 **Contract** – this Certificate of Coverage, any endorsements hereon and attached papers, if any, and the Subscriber's application constitute the entire Contract between UnitedHealthcare and the Subscriber.

1.7 **Contract Period** – refer to Attachment A.

1.8 **Copayment** – the amount, if any, the Member must pay for each covered health service received, such as a doctor visit. The amount is specified per service and is shown in Attachment D. Each Copayment shall be paid at the time the service is provided.

1.9 **Covered Service(s)** – a service, procedure, treatment, supply, device, or item specified in this Contract for which benefits will be provided when medically necessary.

1.10 **Deductible** – the dollar amount, if any, the Member must pay for health services before benefits are payable under this Contract. The amount is shown in Attachment D. Only those charges which would otherwise be payable by UnitedHealthcare in the absence of application of the Deductible shall count toward the Deductible.

1.10.1 The following amounts will not count toward any applicable Deductible:

1.10.1.1 Amounts in excess of the Maximum Allowance, whether or not paid by the Member.

1.10.1.2 Amounts paid by the Member in connection with supplemental benefits, if any supplemental benefits rider is attached to this Contract, such as but not limited to prescription drug, dental, vision, or chiropractic,

1.10.1.3 Penalty amounts paid by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.

1.10.2 **4th Quarter Deductible Carryover:** Dollar amounts incurred by a Member during the last three months of a calendar year, which were counted toward any applicable Deductible during that calendar year of a UnitedHealthcare benefit plan with a 4th Quarter Deductible Carryover provision, will also count toward any applicable Deductible for the following calendar year.

1.12 **Eligible Dependent** – a person who meets UnitedHealthcare's eligibility requirements set forth in Attachment B.

1.13 **Group** – the sole proprietor, partnership, association or corporation, including any and all successors, through which the Member has enrolled, and which has agreed to collect and remit the Premiums payable under this Contract.

1.14 **Home Health Services** – skilled nursing care, when a Member is confined to his or her home related to a recuperative or treatable illness or injury and when provided by a Home Health Agency.

1.15 **Home Health Agency** – a public or private agency that specializes in providing skilled nursing services in the home, and is duly licensed to operate as a Home Health Agency under applicable state or local laws.

1.16 **Hospital** – an acute care general Hospital providing Hospital Services to Members.

1.17 **Hospital Services** – bed and board of the character classed as semiprivate or intensive care and all other services customarily furnished in a Hospital or Skilled Nursing Facility.

1.18 **Maximum Allowance** – the portion of a Non-Participating Provider's charge which UnitedHealthcare will consider in calculating benefits. The Maximum Allowance will be determined based on UnitedHealthcare's determination of the average discount UnitedHealthcare has negotiated with Participating Providers for that service. If the Billed Charge exceeds the Maximum Allowance, the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance, except when services were rendered in a Medical Emergency. Any amount paid by a Member which is in excess of the Maximum Allowance for Covered Services shall not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.]

1.19 **Maximum Out-of-Pocket Expense** – the sum total amount of Copayments, Coinsurance, and Deductibles, as shown for an individual or family in Attachment D and paid by a Member, after which – for the remainder of the calendar year – UnitedHealthcare will pay 100% of the Allowed Charge for that Member's subsequent Covered Services under this Contract.

1.20.1 The following amounts will not count toward any applicable Maximum Out-of-Pocket Expense, and the Member's responsibility for paying these amounts will continue even after the Member has met any applicable Maximum Out-of-Pocket Expense:

1.20.1.1 amounts in excess of the Maximum Allowance.

1. 20.1.2 amounts payable by the Member in connection with supplemental benefits, if any supplemental benefits rider is attached to this Contract, such as but not limited to prescription drug, dental, vision, or hearing.

1.20.1.3 Penalty amounts payable by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.

1.21 **Maximum Policy Benefit** - for benefit plans that have a Maximum Policy Benefit, this is the maximum amount that UnitedHealthcare will pay for benefits during the entire period of time that Members are enrolled under the Contract. Refer to the Attachment D to determine whether or not the benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

1.22 **Medical Emergency** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.22.1 placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy; or

1.22.2 serious impairment of bodily functions; or

1.22.3 serious dysfunction of any bodily organ or part.

1.23 **Medicare** – Title XVIII of the Social Security Act, as amended from time to time.

1.24 **Member** – the Subscriber and any Eligible Dependents who are enrolled in UnitedHealthcare.

1.25 **Non-Participating Physician** – a Physician who has not entered into a Participating Physician's agreement, either with UnitedHealthcare, an entity affiliated with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.

1.26 **Non-Participating Provider** – any Provider licensed to provide medical services, including but not limited to a Physician, Hospital, or extended care facility, that does not have a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.

1.27 **Participating Hospital** - an acute care general Hospital which has entered into a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of Hospital Services to Members.

1.28 **Participating Physician** – a Physician who has entered into a Participating Physician's agreement, either with UnitedHealthcare or with another entity which has a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.

1.29 **Participating Provider** – any Provider, including but not limited to a Physician, Hospital, or extended care facility, that has entered into a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.

1.30 **Penalty** – additional Member payment required as a result of Member's failure to comply with Preauthorization requirements for certain Covered Services from Non-Participating Providers as described in section 6.1.1. The amount is shown in Attachment D. Any Penalty amount paid by the Member will not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.

1.31 **Pharmaceutical Product(s)** - FDA-approved prescription pharmaceutical products administered in connection with a Covered Service by a Physician or other health care Provider within the scope of the Provider's license, and not otherwise excluded under this Certificate of Coverage.

1.32 **Physician** – a person who is properly licensed and qualified by law to practice medicine in any of its

branches.

1.33 **Preauthorization** – as described in section 6.1.1, prior to the time certain services, items, and procedures are furnished, approval from UnitedHealthcare (or, for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider) for those services, items, and procedures to be covered. UnitedHealthcare establishes the criteria used to determine the appropriateness of the services, items, and procedures and the level of care that will be covered. If a Member has any question as to whether or not a service, item, or procedure requires Preauthorization, he or she should contact UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.

1.34 **Primary Care Physician (PCP) –** any Participating Physician who is designated by UnitedHealthcare as a Primary Care Physician.]

1.35 **Provider** – any Provider licensed to provide medical services, including but not limited to a Physician, Hospital, or extended care facility.

1.36 **Premium** – the periodic amount of money currently charged by UnitedHealthcare for benefits and services provided under this Contract.

1.37 **Skilled Nursing Facility** – an extended care facility which is accredited as a Skilled Nursing Facility under applicable state law or is recognized and eligible for payment under Medicare.

1.38 **Specialist** – any Participating Physician who is not designated by UnitedHealthcare as a Primary Care Physician.]

1.39 **Subscriber** – an individual who is eligible to participate in the health benefit plan offered by Group under this Contract and who has enrolled under this Contract.

1.40 **Urgent Care Facility -** a facility that provides Covered Services that are required to prevent serious deterioration of the Member's health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

ARTICLE 2 - ELIGIBILITY DATE/EFFECTIVE DATE

2.1 The eligibility date shall be the date on which a Member is first deemed eligible by UnitedHealthcare to participate under this Contract.

2.2 Eligibility of Subscribers and Eligible Dependents shall be determined as set forth in Attachment B.

2.3 The coverage effective date shall be the date on which a Member is first deemed eligible by UnitedHealthcare to receive benefits under this Contract.

2.4 Benefits shall be provided when the Member receives services on or after the coverage effective date, except as set forth in section 2.6.

2.5 Upon the acquisition of an Eligible Dependent, the Subscriber shall make written notification to the Group within 31days of such change and the coverage effective date will be the acquisition date of the Eligible Dependent. If written notification of the acquisition of an Eligible Dependent is made to the Group more than 31 days after such coverage change, the coverage effective date for such change will not be more than 31 days prior to the date the Group received proper notification.

2.6 **Changes in Eligibility Status.** Subscriber shall provide Group written notification of any dependent status change within 31 days of such change.

2.6.1 The Subscriber's failure to notify Group of a Member's loss of Eligible Dependent status (for example, due to change in student status) shall not extend any person's coverage beyond the last day on which he or she qualifies as an Eligible Dependent.

2.6.2 *Canceling Coverage for Eligible Dependents*: When the Subscriber discontinues coverage for one or more Eligible Dependents, if notification of such change is received more than 31 days after the desired date of coverage change, the implemented date of the change will not be more than 31 days prior to the date Group received proper notification to remove the Eligible Dependent(s) from coverage.

2.6.3 *Adding Eligible Dependents*: See *Special Enrollment,* section 2.7 of this Article.

2.7 **Special Enrollment.** UnitedHealthcare shall provide a Special Enrollment Period during which an eligible individual may enroll for coverage under this Contract under certain conditions. For purposes of this section, the term "Special Enrollment Period" means a period during which an eligible employee is allowed to request coverage for himself/herself and/or any Eligible Dependents upon the occurrence of certain events and conditions as described below in sections 2.7.1, 2.7.2, and 2.7.3.

2.7.1 *Prior coverage terminated or exhausted.* A Special Enrollment Period is available due to loss of group or other health insurance coverage as described in this section.

2.7.1.1 *Coverage loss which creates special enrollment opportunity*. Special enrollment is available to persons specified in section 2.7.1.2 when:

2.7.1.1.1 COBRA continuation coverage with a prior carrier is exhausted; or

2.7.1.1.2 Coverage under another group health plan or other health insurance coverage, which is not under COBRA continuation coverage, has terminated as a result of (a) loss of eligibility for reasons such as legal separation, divorce, death, termination of employment or reduction in the number of hours worked, (b) cessation of employer contributions, (c) the plan no longer offers benefits to a class of individuals that include the eligible employee and/or Eligible Dependent, (d) the eligible employee and/or Eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits, or (e) the eligible employee and/or Eligible Dependent loses eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

2.7.1.2 *Persons who may be entitled to special enrollment due to loss of prior coverage*. A Special Enrollment Period will be allowed for the persons described below when a loss of coverage described in section 2.7.1.1 has occurred, and if enrollment takes place during the Special Enrollment Period:

2.7.1.2.1 *For an eligible employee*, upon losing coverage under another plan.

2.7.1.2.2 *For an Eligible Dependent*, upon losing coverage under another plan, but only if such individual is an Eligible Dependent of an employee who is already covered under this Contract.

2.7.1.2.3 *For both the eligible employee and the employee's Eligible Dependent*, if either loses coverage under another plan.

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

2.7.1.3.1 The individual must be eligible to enroll under this Contract; and

2.7.1.3.2 The individual declined coverage under this Contract when the person first became eligible; and

2.7.1.3.3 When the individual declined such coverage, the individual was covered under another group's health plan or other health coverage; and

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

2.7.1.4 *Special Enrollment Period for Section 2.7.1.* To enroll due to loss of coverage, the employee must apply for coverage for the employee and/or Eligible Dependent within 31 days of loss of coverage, except that in order to enroll due to loss of eligibility for Medicaid or CHIP the employee must apply for coverage for the employee and/or Eligible Dependent within 60 days of loss of Medicaid or CHIP coverage.

2.7.2 *Acquisition of a Dependent*. A Special Enrollment Period will be allowed for the persons described below when the described events occur, and if they request coverage during the Special Enrollment Period stated in section 2.7.2.6.

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

2.7.2.2 *For an individual who becomes a spouse of a Subscriber*: at the time of marriage, or when a child becomes an Eligible Dependent of that Subscriber as the result of birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.3 *For both an employee who is eligible but not enrolled and an eligible spouse*: when they marry or when a child becomes an Eligible Dependent of the employee as a result of birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.4 *For a child*: upon becoming an Eligible Dependent of a Subscriber as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

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

2.7.2.6 *Special enrollment period for section 2.7.2*. The employee must request coverage for the employee and/or Eligible Dependent/s within 31 days from the date of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption.

2.7.3 *Eligibility for State Premium Assistance Subsidy*. A Special Enrollment Period will be allowed for both an eligible employee and/or the employee's Eligible Dependent if the eligible employee and/or Eligible Dependent become eligible for a state premium assistance subsidy for employer group health coverage. To enroll pursuant to this Section 2.7.3, the employee must apply for

coverage for the employee and/or Eligible Dependent within 60 days of the date of eligibility for the subsidy.

2.7.4 *Effective date of Enrollment*. For those enrolled during a Special Enrollment Period, enrollment is effective as follows:

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

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

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

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

2.7.4.5 *Eligibility for State Premium Assistance Subsidy*. In the case of the eligible employee and/or Eligible Dependent becoming eligible for a state premium assistance subsidy for employer group health coverage, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

2.7.5 For purposes of counting creditable coverage, the enrollment date for anyone who enrolls under a Special Enrollment Period is the first day of coverage. That is, the time between the date an individual becomes eligible for enrollment under this Contract and the first day of coverage is not treated as a waiting period.

ARTICLE 3 – PARTICIPATING AND NON-PARTICIPATING PROVIDERS

3.1 **Participating Providers.** When a Member uses Participating Providers, the Participating Providers are responsible for making arrangements with UnitedHealthcare for coverage of a Member's care, including but not limited to complying with the medical management requirements set forth in Article 6, and for submitting claims. Covered Services from Participating Providers will be paid at the "In-Network" level of benefits shown in Attachment D.

3.2 **Non-Participating Providers.** When a Member uses Non-Participating Providers, the Member is responsible for making arrangements with UnitedHealthcare for coverage of his or her care, including but not limited to complying with the medical management requirements set forth in Article 6, and for submitting claims for reimbursement in accordance with Article 11.

3.2.1 **Non-Participating Providers – Medical Emergency.** Covered Services from Non-Participating Providers in a Medical Emergency will be paid at the "In-Network" level of benefits shown in Attachment D, and the Member is not responsible for paying any amounts or charges exceeding the Maximum Allowance.

3.2.2 **Non-Participating Providers – Non-Emergency.** Non-emergency Covered Services from Non-Participating Providers will be paid at the "Out-of-Network" level of benefits shown in Attachment D, and the Member is responsible for paying any amounts or charges exceeding the Maximum Allowance.

3.3 **WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS**

ARE USED. Members should be aware that when they elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. **MEMBERS CAN EXPECT TO PAY MORE THAN THE DEDUCTIBLE AND COINSURANCE AMOUNTS DEFINED IN THIS CONTRACT AFTER UNITEDHEALTHCARE HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the Billed Charge after UnitedHealthcare has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the Member other than Copayments, Coinsurance, and Deductible amounts. Members may obtain further information about the participating status of professional Providers and information on Maximum Out-of-Pocket Expenses by calling UnitedHealthcare at the toll-free telephone number on the back of their identification card.

3.4 Charges for any service not payable to a Participating Provider will not be payable to a Non-Participating Provider.

3.5 Participating Providers are listed in the UnitedHealthcare provider directory. A Provider's status may change. Before obtaining services, a Member should verify the network participation status of a Provider. If a Member has any question as to whether or not a Provider is a Participating Provider, he or she should call UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.

ARTICLE 4 – GENERAL PROVISIONS FOR BENEFITS

4.1 Payment will not be made for any services provided to a Member unless such service is listed and described in Attachment D. If a Member has any question as to whether or not a specific service is covered, he or she should call UnitedHealthcare at the toll-free telephone number listed in Attachment C.

4.2 All services, whether provided by a Participating or a Non-Participating Provider, are subject to evaluation by UnitedHealthcare for appropriateness of care and case management if necessary.

4.3 Benefits will be paid only for a service, procedure, treatment, supply, device, or item, Hospital, medical or otherwise, which is medically necessary. To be medically necessary the service or treatment must meet the following criteria as determined by UnitedHealthcare and, if required by UnitedHealthcare, must be authorized on a prospective and timely basis by UnitedHealthcare:

4.3.1 The service or treatment is consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Member's medical condition; and

4.3.2 The service or treatment is performed in the most cost-effective manner in terms of treatment, method, setting, frequency and intensity, taking into consideration the Member's medical condition.

4.4 UnitedHealthcare has the right to require Preauthorization in regard to any service provided by a Participating or Non-Participating Provider. Preauthorization requirements are set forth in section 6.1.1.

4.5 While a Member may consult with a Physician or other Provider about treatment which is excluded in Article 8 of this Contract or otherwise not covered, should the Member decide to follow a course of treatment which is excluded or not covered, UnitedHealthcare will not pay for such treatment.

ARTICLE 5 – SCHEDULE OF BENEFITS

5.1 Benefits listed under this Article will be paid subject to the provisions of Attachment D.

5.1.1 **Participating Provider.** The "In-Network" level of benefits will be paid when Covered Services are provided by a Participating Provider.

5.1.2 **Non-Participating Provider – Medical Emergency.** Covered Services from a Non-Participating Provider due to a Medical Emergency will be paid at the "In-Network" level of benefits shown in Attachment D.

5.1.3 **Non-Participating Provider – Non-Emergency.** Non-emergency Covered Services from a Non-Participating Provider will be paid at the "Out-of-Network" level of benefits shown in Attachment D.

5.2 **Preventive Care Examinations and Associated Services.** Benefits are available for Preventive Care examinations (well-baby, well-child, well-adult care) and associated services including, but not limited to, immunizations to prevent or arrest the further manifestation of human illness or injury, laboratory testing or screening, x-rays, uterine cervical-cytological testing (Pap testing) and low-dose mammography testing. "Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.

5.3 **Physician Medical Services.** Benefits are available for the following services when performed for the treatment of illness or injury:

5.3.1 Office visits.

5.3.2 Office consultations.

5.3.3 Injections which are not usually self-administered.

5.3.4 Surgical care and associated anesthesia, including maternity care.

5.3.5 X-ray and laboratory tests and services, including pathology services and radiation therapy, for the treatment of illness or injury.

5.3.6 Blood transfusion services.

5.3.7 Hospital visits, Skilled Nursing Facility visits, and home visits.

5.3.8 Newborn care from the moment of birth, including well-care and care for the treatment of illness, injury, congenital defects, birth abnormalities and premature birth.

5.3.9 Casts and dressings

5.3.10 Medical eye exams (refer to section 8.10 for exclusions)

5.3.11 All covered medical supplies furnished in connection with the services provided above.

5.4 **Allergy Testing and Injections.** Benefits are available as described in Attachment D.

5.5 **Inpatient Services.** Benefits are available for services received in an acute care Hospital or Skilled Nursing Facility for room and board at the semi-private or intensive care level, less any applicable Copayment, Coinsurance, or Deductible. For a private room, the Member shall pay directly to the facility the difference between its regular charge for the private room and its most common charge for a semi-private room, as well as any applicable Copayment, Coinsurance, or Deductible. However, if a private room is authorized as medically necessary by UnitedHealthcare, then the private room charge shall be covered, less any applicable Copayment, Coinsurance, or Deductible. Room and board includes all charges made by a Hospital on its own behalf for the room, meals, and for all general services and activities needed

for the care of a registered bed patient. Also covered are the miscellaneous medical services and supplies used during the confinement such as, but not limited to, diagnostic x-rays and laboratory tests, and the administration of anesthesia, whole blood and blood derivatives.

In an intensive care unit, a Member shall be entitled to all services of the intensive care unit.

5.6 **Outpatient Hospital and Ambulatory Care Services.** Charges incurred as a result of surgery performed as an outpatient or in an ambulatory care setting are covered.

5.7 **Emergency Services.** Whenever possible, a Member should contact his or her Physician prior to receiving treatment for a Medical Emergency. If the Physician is not immediately available, the Member should seek emergency care at the most convenient health care facility.

5.7.1 **Emergency Services.** When a Medical Emergency occurs, the Member should seek care immediately from a Hospital or other emergency facility. If it is determined that a Medical Emergency existed, or that the visit to the Hospital or other emergency facility was medically necessary, the initial visit will be covered. Follow-up care received in a Hospital or an emergency facility is not covered; the Member must arrange follow-up care with a Physician.

5.7.2 **Determination of Covered Benefits.** The determination of covered benefits for services rendered in a Hospital or emergency facility is based on UnitedHealthcare's review of the Member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. If it is determined that a Medical Emergency did not exist, or that services were not medically necessary, the Member will be held financially responsible for those services. As a general rule, for UnitedHealthcare to determine that a Medical Emergency existed or that services were medically necessary, the date of the onset of symptoms and the date of treatment as reported on the claim form should be the same but not more than 24 hours after an illness or injury.

5.7.3 **Notification After Services are Received.** If due to the severity of his or her condition, the Member was unable to notify his or her Physician prior to seeking emergency care, the Member should notify his or her Physician within 48 hours after treatment is rendered, or as soon as reasonably possible. If the Member is unable to notify due to his or her condition, or if the patient is a minor, this 48-hour period will be reasonably extended until the Member or a responsible adult is able to notify.

5.8 **Ambulance Services.** For Medical Emergencies, ambulance services will be covered to the nearest facility that is equipped and staffed to provide necessary services. Preauthorization is not required to access an emergency 911 system or other state, county or municipal emergency medical system for ambulance services. For non-emergencies, when medically necessary, a Member shall be entitled to coverage for ambulance services to a Hospital, between Hospitals when needed specialized care cannot be obtained at the first Hospital, and between a Hospital and a Skilled Nursing Facility.

5.9 **Home Health Services.** A Member confined to his or her home may be entitled to skilled nursing services provided by a Home Health Agency. Such visits shall include part-time or intermittent home health care by or under the supervision of a registered nurse. A skilled nursing visit of four hours or less shall equal one home health visit. Before Home Health Services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

5.10 **Hospice Services.** Benefits are provided for outpatient Hospice Services to a Member with a Terminal Illness. Before Hospice Services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

5.10.1 For the purposes of this section, the following definitions apply:

5.10.1.1 "Hospice Services" means a coordinated program of outpatient care provided directly by or under the direction of a Medicare-certified hospice agency or Medicare-certified home health agency, and includes Palliative Care and supportive physical, psychological, psychosocial and other health services, utilizing a medically-directed interdisciplinary team.

5.10.1.2 "Member with a Terminal Illness" means a Member whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who has elected to receive Palliative Care rather than curative care.

5.10.1.3 "Palliative Care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the Member's special needs while experiencing the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of curing or of prolonging life.

5.10.2 There may be clinical situations when short episodes of acute care would be appropriate even when the Member remains in the hospice setting. While these acute care services are not payable under the Hospice Services benefit, they may be Covered Services under other sections of this Contract.

5.10.3 **Exclusion applicable to Hospice Services.** Charges for room and board are specifically excluded from the Hospice Services benefit. If a Member receives Hospice Services in his or her home, or while living in a nursing home or residential facility, room and board will not be covered under this Contract.

5.11 **Durable Medical Equipment.** Benefits are payable for the rental of Durable Medical Equipment for home use in the treatment of an injury or illness or for the improvement of the function of a malformed body member. In some cases, UnitedHealthcare may determine that purchase of the equipment is more appropriate than rental. Benefits will not be paid for special features or equipment requested by the Member for personal comfort or convenience.

"Durable Medical Equipment" means medical equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) is not useful in the absence of illness or injury, and (d) is appropriate for home medical treatment.

5.12 **Prosthetic Devices.** Coverage for Prosthetic Devices includes (a) initial placement of a Prosthetic Device and its supportive device, (b) maintenance and repair required for the successful use of the device, (c) replacement of a device when required by growth or change in medical condition, and (d) replacement of a device due either to wear and tear or to technological improvement and determined to be medically necessary.

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

5.13 **Organ and Tissue Transplants.** Organ and tissue transplant services described in this section must be ordered by the Member's Attending Physician and received from transplant centers approved by UnitedHealthcare; otherwise, benefits will not be paid. Before organ and tissue transplant services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

Benefits for all organ and tissue transplant services will be payable as shown in Attachment D. This restriction applies to all services performed in conjunction with the transplant. Transplant services for a Member who is the recipient of an organ or tissue transplant include all professional, technical and facility charges (inpatient and outpatient) for evaluation of the transplant procedure and follow-up care (twelve months). If the recipient is a Member, professional, technical and facility charges for removal of the

donated organ or tissue, as well as any complication resulting from the donation, are also covered by UnitedHealthcare for a live primary donor up to 90 calendar days after the date of the donation, if such donation is not covered by other insurance. Organ and tissues covered for transplant include: heart, heart/lung, kidney, kidney/pancreas, liver, lung, bone marrow and stem cell.

If a Member is registered at two or more transplant centers for the same transplant (i.e. "multiple listing"), UnitedHealthcare will pay for Covered Services associated with only one approved transplant center waiting list. UnitedHealthcare will not pay for any charges related to additional transplant center waiting lists.

UnitedHealthcare has specific guidelines regarding benefits for transplant services. The Member should contact UnitedHealthcare at the telephone number on the back of the ID card for information about these guidelines.

5.14 **Cornea Transplants.** Benefits are available as described in Attachment D.

5.15 **Temporomandibular Joint Syndrome.** Diagnosis and surgical treatment of temporomandibular or craniomandibular joint syndrome or disorders (hereafter called 'TMJ syndrome'), which is due to a medical condition or injury that prevents normal function of the joint or bone and is medically necessary to attain functional capacity of the affected part, will not be more limited or restricted than coverage applicable for such treatment involving any bone or joint of the skeletal structure. Osteotomy is not a covered treatment for TMJ syndrome.

5.16 **Outpatient Rehabilitative Therapy.** Outpatient rehabilitative therapy benefits will be paid for conditions resulting from disease or injury or when prescribed immediately following surgery related to the condition. Outpatient rehabilitative therapy includes physical, occupational, and speech therapy and cardiac (phase I and II) and pulmonary rehabilitation. Therapy must be ordered by a Physician and performed by a licensed therapist acting within the scope of his or her licensure.

5.16.1 Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy. Occupational therapy performed by an occupational therapist will be covered to the extent that such therapy is performed to regain use of the upper extremities.

5.16.2 Speech therapy will be covered only for treatment of a residual speech impairment resulting from a stroke, accidental injury or surgery to the head or neck or for treatment of a pervasive developmental disorder.

5.16.3 Cardiac rehabilitation requires continuous ECG monitoring to be covered. Only monitored (Phase I and II) cardiac rehabilitation is covered.

5.16.4 Pulmonary rehabilitation program is payable once per lifetime for a Member. Pulmonary rehabilitation does not count toward any applicable maximum number of Outpatient Rehabilitative Therapy treatment visits shown in Attachment D.

5.17 **X-ray and Laboratory Services.** Benefits are payable for diagnostic x-ray and laboratory services performed for the diagnosis and/or treatment of an illness or injury, including, but not limited to, x-ray films and scans, such as computerized axial tomography (CAT) scans, electrocardiograms (EKGs), ultrasound examinations, mammography, and blood, urine and pathology (tissue) tests.

5.18 **Radiation Therapy and Chemotherapy.** Benefits are payable for radiation therapy (such as x-ray and radium) received in connection with the treatment of malignancies and certain other tumors; and generally accepted chemotherapy received for the treatment of malignancies.

5.19 **Renal Dialysis Services.** Benefits are available as described in Attachment D.

5.20 **Mental Health Services.** Benefits for Hospital Services or medical care for mental health shall be covered, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for the purposes of determining any limitations and Deductible, Copayment, and Coinsurance. Any day of confinement, service provided, or examination must have Preauthorization from UnitedHealthcare's mental health treatment program provider, except when a Medical Emergency exists. The Member may contact UnitedHealthcare's mental health treatment program provider at the toll-free telephone number listed on the back of the Member's UnitedHealthcare identification card to request a list of Participating Providers or for more information on the procedures to be followed.

5.20.1 **Inpatient Facility Services.** If a Member is confined as a resident inpatient in a Hospital, Non-Acute Hospital, or other residential treatment facility and enrolled in a treatment program for a psychiatric, mental, or nervous condition or disorder, benefits will be paid according to the provisions of Attachment D and section 5.5.

5.20.2 **Outpatient Facility Services.** Outpatient facility service benefits will be paid if a Member receives Hospital outpatient medical services at a Hospital, Non-Acute Hospital, or other treatment facility and is enrolled in an outpatient treatment program for a psychiatric, mental, or nervous condition or disorder. Benefits will be paid according to the provisions of Attachment D and section 5.6.

"Non-Acute Hospital" as used in this section means a facility which is not licensed to operate as an acute care general Hospital.

5. 20.3 **Physician Services.** If a Member shall receive psychiatric or professional services by a Physician acting within the scope of his or her licensed authority, or other licensed mental health Provider, for a psychiatric, mental or nervous condition or disorder, benefits will be paid subject to Attachment D and the following provisions:

5.20.3.1 **Hospital Inpatient Physician Services.** Hospital inpatient Physician services benefits will be paid if the Member is confined as a resident inpatient in a Hospital as described in section 5.5.

5.20.3.2 **Hospital Outpatient Physician Services.** Hospital outpatient Physician services benefits will be paid if the Member receives Hospital outpatient services as described in section 5.6.

5.20.3.3 **Physician Office Services.**

5.20.4 **Exclusions and Limitations Applicable to Mental Health Benefits.** See section 8.43.

5.21 **Substance Abuse Services.** Benefits for Hospital Services or medical care for substance abuse including alcoholism shall be covered, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for the purposes of determining any limitations and Deductible, Copayment, and Coinsurance. Any day of confinement, service provided, or examination must have Preauthorization from UnitedHealthcare's substance abuse treatment program provider, except when a Medical Emergency exists. The Member may contact UnitedHealthcare's substance abuse treatment program provider at the toll-free telephone number listed on the back of the Member's UnitedHealthcare identification card to request a list of Participating Providers or more information on the procedures to be followed.

5.21.1 **Inpatient Facility Services.** If a Member is confined as a resident inpatient in a Hospital, Non-Acute Hospital, or other residential treatment facility and enrolled in a treatment program for substance abuse, benefits will be paid according to the provisions of Attachment D and section 5.5.

5.21.2 **Outpatient Facility Services.** Outpatient facility service benefits will be paid if a Member receives Hospital outpatient medical services at a Hospital, Non-Acute Hospital, or other treatment facility and is enrolled in an outpatient treatment program for substance abuse. Benefits will be paid according to the provisions of Attachment D and section 5.6.

"Non-Acute Hospital" as used in this section means a facility which is not licensed to operate as an acute care general Hospital.

5.21.3 **Physician Services.** If a Member shall receive psychiatric or professional services by a Physician acting within the scope of his or her licensed authority, or other licensed mental health Provider, for substance abuse, benefits will be paid subject to Attachment D and the following provisions:

5.21.3.1 **Hospital Inpatient Physician Services.** Hospital inpatient Physician services benefits will be paid if the Member is confined as a resident inpatient in a Hospital as described in section 5.5.

5.21.3.2 **Hospital Outpatient Physician Services.** Hospital outpatient Physician services benefits will be paid if the Member shall receive Hospital outpatient services as described in section 5.6.

5.21.3.3 **Physician Office Services.**

5.21.4 **Exclusions and Limitations Applicable to Substance Abuse Benefits.** See section 8.43.

5.22 **Reconstructive Surgery.** Benefits are provided for reconstructive surgical procedures which are medically necessary to repair a functional disorder as a result of disease, injury or congenital anomaly. Benefits are also provided for: all stages of reconstructive breast surgery as a result of a mastectomy; reconstructive surgery necessary to re-establish symmetry between the two breasts; prostheses; and treatment of physical complications including treatment of lymphedemas at all stages of the mastectomy. Benefits for reconstructive surgery as a result of a mastectomy are provided in a manner determined in consultation with the attending Provider and the patient.

5.23 **Maternity Care.** Benefits are provided for maternity care, including prenatal and post-natal care and care for complications of pregnancy. With regard to post-parturition care, coverage is as follows: (a) a minimum of 48 hours of inpatient care for the mother and newborn, following a vaginal delivery, or (b) a minimum of 96 hours of inpatient care for the mother and newborn, following a delivery by caesarian section. A shorter length of stay for services related to maternity and newborn care may be provided if after consultation with the mother or upon consent of the mother the Attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn. If a shorter length of stay is determined to be appropriate in accordance with these guidelines, the mother and newborn shall have coverage for an office visit or home-nurse visit within 48 hours of discharge.

5.24 **Diabetes Self-Management/Supplies.** Benefits are provided for equipment and supplies (including, but not limited to, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, and lancets). Outpatient self-management training and education must be provided in person by a certified, registered, or licensed health care professional. Note that benefits for diabetic equipment and supplies will be paid according to the Durable Medical Equipment provisions of Attachment D

5.25 **Certain Clinical Trials for Treatment Studies on Cancer approved by National Cancer Institute (NCI) or National Institutes of Health (NIH).**

5.25.1 Coverage is provided for Patient Costs, as defined below, incurred by Member during participation in any phase of clinical trials for treatment studies on cancer but only when all of the following conditions are met:

5.25.1.1 There is no clearly superior, non-investigational treatment alternative;

5.25.1.2 The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative;

5.25.1.3 The Member and Member's Attending Physician conclude that the Member's participation in the clinical trial would be appropriate;

5.25.1.4 The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise; and

5.25.1.5 The treatment is provided by a clinical trial approved by one of the following: (a) the NCI, (b) an NCI Cooperative Group, or (c) an NCI center or the federal Department of Veterans Affairs. "Cooperative Group" means a formal network of facilities that collaborate on research projects and have an established NCI-approved peer review program operating within the group. Cooperative Group includes the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

5.25.2 Coverage of Patient Costs incurred during participation in a clinical trial shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures.

5.25.3 "Patient Costs" means the costs of Covered Services that are incurred as a result of the treatment being provided to Member for purposes of a clinical trial. Patient Costs do not include:

5.25.3.1 the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial;

5.25.3.2 costs associated with managing the research associated with the clinical trial;

5.25.3.3 the cost of the investigational procedure, drug, pharmaceutical, device, or clinical trial therapies, regimens, or combinations thereof;

5.25.3.4 costs associated with the provision of any goods, services, or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer;

5.25.3.5 additional costs associated with the provision of any goods, services, or benefits that previously have been provided to, paid for, or reimbursed, or any similar costs; or

5.25.3.6 treatments or services prescribed for the convenience of the Member or his or her Attending Physician.

5.26 **General Anesthesia for Dental Procedures.** Benefits are payable for general anesthesia and Hospital or ambulatory surgical treatment center charges for dental treatment care if any of the following applies:

5.26.1 Member is age 8 years or younger;

5.26.2 Member is Disabled (see definition below); or

5.26.3 As used in section 5.26.2 above, "Disabled" means a person of any age with a chronic disability which meets all of the following conditions: (a) it is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) it is likely to continue; and (c) it results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self-sufficiency.

5.26.4 Benefits under section 5.26 are subject to any limitation, exclusion, Copayment, Coinsurance, Deductible, or Penalty provision which applies generally under this Contract.

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

5.28 **Urgent Care Facility Services.** Services received at an Urgent Care Facility are available as described in Attachment D.

5.29 **Spinal Manipulative Services.** Benefits will be payable for Members for spinal manipulative services provided by a licensed Doctor of Chiropractic (D.C.). Services covered are diagnostic evaluation and x-ray services for the purpose of diagnosing the appropriateness of spinal manipulation treatment, diathermy, electric stimulation, emergency room, massage, medical supplies, office visits, spinal manipulation, traction, and ultrasound. Benefits payable for these services do not apply toward any Outpatient Rehabilitative Therapy limits as defined in Attachment D. Network Services are provided by a Network Provider who has entered into an agreement with ACN Group, Inc. (ACN) for UnitedHealthcare. Services are subject to preauthorization by ACN. Services provided by a Non-Network Provider must be preauthorized by ACN and will be paid according to Attachment D.

5.29.1 **Exclusions Applicable to Spinal Manipulative Services:** See section 8.45.

ARTICLE 6 – MEDICAL MANAGEMENT PROCESSES

6.1 UnitedHealthcare utilizes the following medical management processes for services from Participating and Non-Participating Providers:

6.1.1 **Preauthorization.** Some services, items, and procedures, including certain medical and diagnostic procedures, require approval by UnitedHealthcare prior to the time those services, items, and procedures are furnished ("Preauthorization"). UnitedHealthcare establishes the criteria used to determine the appropriateness of the services, items, and procedures and the level of care that will be covered.

6.1.1.1 *When a Member uses Participating Providers:* The Member *is not* responsible for obtaining Preauthorization. Participating Providers are responsible for complying with Preauthorization requirements.

6.1.1.2 *When a Member uses Non-Participating Providers:* The Member *is* responsible for obtaining Preauthorization.

6.1.1.3 *When a Member fails to obtain Preauthorization:* If the Member fails to obtain Preauthorization for services, items, or procedures from Non-Participating Providers, and UnitedHealthcare determines the services, items, or procedures were medically necessary, the services, items, or procedures will be covered, but the Member will pay a Penalty, in

addition to any applicable Deductible and/or Coinsurance, as set forth in Attachment D. Any Penalty amount paid by the Member will not count toward any applicable Deductible or Maximum Out-of-Pocket Expense. If UnitedHealthcare determines that the services, items, or procedures were not medically necessary, the Member will be responsible for paying the Non-Participating Provider all charges for such services, items, and procedures.

6.1.1.4 If a Member has any question as to whether or not a service, item, or procedure requires Preauthorization, the Member should call UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.

6.1.1.5 When Preauthorization is required prior to rendering treatment, UnitedHealthcare will have personnel available to provide such Preauthorization.

6.1.1.6 Section 6.1.1 also applies to mental health and substance abuse services, as described in sections 5.20 and 5.21, with the following exception: Preauthorization must be obtained from UnitedHealthcare's mental health and/or substance abuse treatment program provider. The toll-free telephone number for UnitedHealthcare's mental health and/or substance abuse treatment program provider is listed on the back of the Member's UnitedHealthcare identification card.

6.1.2 **Hospital or Nursing Facility Continued Stay Review.** Continued stays at a facility may be reviewed for appropriateness of care and services. This review will be performed by UnitedHealthcare. If a continued stay is determined by UnitedHealthcare to be no longer medically necessary, UnitedHealthcare may contact the Attending Physician to determine the need for the continued stay and request a plan of treatment. Any charges for services provided following the determination by UnitedHealthcare that services are not medically necessary will not be paid by UnitedHealthcare and will not be counted toward any applicable Deductible or Maximum Out-of-Pocket Expense limits.

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

ARTICLE 7 - MEMBER PAYMENTS DIRECTLY TO PROVIDERS

7.1 If any services not included in or covered by this Contract are provided to a Member, or if any Copayments, Coinsurance, Deductibles, and/or Penalty amounts apply as shown in Attachment D, the Member shall make direct payment to the Provider of such services.

ARTICLE 8 - EXCLUSIONS APPLICABLE TO THE CONTRACT

In addition to specific exclusions listed under individual Articles, benefits shall not be provided for any of the following:

8.1 Any service or treatment, Hospital, medical, or otherwise, which is not medically necessary as described and defined in section 4.3, or any medical complication resulting from a service, treatment, procedure, or device which is not covered under this Contract .

8.2 Shift care, 24-hour nursing, or private duty nursing services in the Hospital, home or Skilled Nursing Facility.

8.3 Care for conditions that federal, state or local law requires be treated in a public facility, Hospital, or other health care facility.

8.4 If the Member's condition is custodial, which means that his or her care consists of watching, maintaining, protecting or is for the purpose of providing personal needs, UnitedHealthcare does not pay for a person or facility to provide any of, but not limited to, the following:

8.4.1 assistance in the activities of daily living, such as walking, dressing, getting in and out of bed, bathing, eating, feeding or using the toilet or help with other functions of daily living or personal needs of a similar nature;

8.4.2 changes of dressings, diapers, protective sheets or periodic turning or positioning in bed;

8.4.3 administration of or help in using or applying medications, creams and ointments, whether oral, inhaled, topical, rectal or injection;

8.4.4 administration of oxygen;

8.4.5 care or maintenance in connection with casts, braces, or other similar devices;

8.4.6 care in connection with ostomy bags or devices or in-dwelling catheters;

8.4.7 feeding by tube including cleaning and care of the tube site;

8.4.8 tracheostomy care including cleaning, suctioning and site care;

8.4.9 urinary bladder catheterization;

8.4.10 monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer; or

8.4.11 general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

8.5 Hospital, personal care or convenience items or services including, but not limited to: television, telephone, newborn infant photos, complimentary meals, birth announcements, or other articles which are not for specific treatment of illness or injury. Also, benefits are not provided for:

8.5.1 private room or special diets unless medically necessary;

8.5.2 housekeeping, homemaker service, and caregiver room/board;

8.5.3 purchase or rental of household equipment or fixtures such as air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses, waterbeds, escalators, elevators, saunas, or swimming pools; or

8.5.4 charges for diversional activities such as recreational, hobby or craft equipment or fees.

8.6 Surgical excision or reformation of any sagging skin on any part of the body including but not limited to eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with enlargement, reduction, implantation, or change in appearance in any portion of the body including but not limited to, breasts, face, lips, jaw, chin, nose, ears or genitals; hair transplantation; chemical face peels or

abrasions of skin; electrolysis depilation; treatment of birthmarks or superficial veins; any other surgical or non-surgical procedures which are performed for cosmetic purposes. However, benefits will be payable for certain reconstructive surgery as described in section 5.22.

8.7 Any fees for the services of Providers that are not Physicians if the fees or charges therefore are claimed by Hospitals, laboratories, or other institutions or for the service of any assisting Physician not authorized by a Provider.

8.8 Dental care.

8.8.1 Any fees involving any types of services in connection with dentistry are excluded, including but not limited to:

8.8.1.1 the care, filling, removal or replacement of teeth or of the structures supporting the teeth;

8.8.1.2 surgical augmentation for orthodontics or maxilla (upper jaw) or mandible (lower jaw) construction; or

8.8.1.3 orthognathic surgery, which refers to any surgical procedure performed to correct skeletal malposition or misalignment of the maxilla and/or mandible, including osteotomy or condylotomy.

8.8.2 Exceptions to this exclusion are as follows:

8.8.2.1 Reconstructive surgery as provided in section 5.22;

8.8.2.2 General anesthesia for dental procedures as provided in section 5.26;

8.8.2.3 Surgical and non-surgical procedures resulting directly from: (a) neoplasms that require treatment to the jaws, cheeks, lips, tongue, or roof or floor of mouth; or (b) accidental injury to natural permanent teeth for which the Member seeks treatment within 60 days of the injury. "Injury" does not include fractures of restorations or teeth resulting from routine daily functions. Preauthorization is required prior to any such treatment, procedure or service described in this section;

8.8.2.4 If dental coverage is provided in a supplemental benefits rider attached hereto; or

8.8.2.5 Coverage for treatment of temporomandibular or craniomandibular joint syndrome (TMJ) as described in section 5.15.

8.9 The following items, unless provided in a supplemental benefits rider attached hereto:

8.9.1 dental prostheses; or

8.9.2 eye glasses or contact lenses

8.10 Routine eye examinations or refractions, including examinations for astigmatism, myopia, or hyperopia, unless a supplemental benefits rider is attached hereto.

8.11 Augmentative communication devices, unless medically necessary.

8.12 Special shoes unless an integral part of a brace or part of diabetes treatment; corrective footwear; foot orthotic devices and supplies unless part of diabetes treatment; routine foot care, including trimming of corns, calluses and nails unless part of diabetes treatment; corsets, other articles of clothing, or cosmetic devices.

8.13 Treatment provided in a government Hospital; services performed by a Member for a Member's immediate family; and services for which no charge is normally made.

8.14 Services for any illness, injury or disease that is covered, in whole or in part, by any employer's plan or coverage designed to comply with any state or federal workers' compensation, employer's liability or occupational disease law (collectively, workers' compensation law), or, with respect to the Subscriber, any illness, injury or disease that could be covered, in whole or in part, by such plan or coverage if the employer is required by applicable federal, state, or local law to have such plan or coverage. If UnitedHealthcare makes payment for such services, it shall be entitled to a lien upon any amounts it paid for which the employer's workers' compensation plan or coverage should have been liable.

8.15 Any service which can be performed in the setting by a person who does not have professional qualifications but has been trained to perform the service.

8.16 Experimental and/or investigational drugs, devices, medical treatment or procedures.

8.16.1 A drug, device, treatment or procedure is experimental and/or investigational if:

8.16.1.1 the drug or device requires approval of the Food and Drug Administration and the drug or device has not been approved when furnished (a drug or device approved for experimental and/or investigational use is deemed to be experimental and/or investigational) except that coverage is provided for a drug which has been prescribed for a treatment for which the drug has not been approved by the FDA, provided the drug is recognized for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (1) the *U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional* (USPDI); (2) the *American Medical Association's Drug Evaluations* (AMADE); or (3) the *American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information* (AHES-DI) or, it is recommended by a clinical study or review article in a major peer reviewed professional journal. However, there is not coverage for any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

8.16.1.2 the drug, device, treatment or procedure is being provided according to a written protocol which describes as an objective determining the safety, toxicity, efficacy or effectiveness of the drug, device, treatment, or procedure as compared with the standard means of treatment or diagnosis for the Member's medical condition; or

8.16.1.3 Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's medical condition.

8.16.2 For the purposes of this Article, "Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature.

8.16.3 Treatment provided in a phase I, II, or III clinical trial will be deemed to be experimental and/or investigational unless Reliable Evidence establishes that the treatment is not experimental and/or investigational for the Member's medical condition. Exception: "Patient Costs" incurred as a result of a Member's participation in certain National Cancer Institute-approved and National Institutes of Health-approved clinical trials for cancer are covered as described in section 5.25.

8.17 Biofeedback treatment except in conjunction with physical therapy performed for the treatment of urinary incontinence.

8.18 Holistic medicine; massage therapy; acupuncture; hypnotherapy; sleep therapy; vocational, rehabilitational or employment counseling; marriage and sex counseling; behavior training, conduct disorders and related family counseling; remedial education and treatment of learning disabilities.

8.19 Charges of a Non-Participating Provider in excess of the Maximum Allowance, unless due to a Medical Emergency.`

8.20 Drugs, medicines, or any implants or devices used in conjunction with birth control regardless of the intended use, unless provided in a supplemental benefits rider attached hereto.

8.21 Ergometers, exercise bikes, or other similar devices.

8.22 Diet or weight loss programs, nutritional counseling, dietary supplements, nutritional formulas and supplements, and megavitamin therapy. Exceptions to this exclusion are as follows:

8.22.1 Medical nutritional therapy will be covered for up to two medically necessary visits per calendar year for hypertension and myocardial infarction; or

8.22.2 Medical nutritional therapy will be covered under a diabetes self-management program as described in section 5.24.

8.23 Illness contracted or injuries sustained as the result of war, declared or undeclared, or any act or hazard of war.

8.24 Illness contracted or injuries sustained as the result of or while in the armed services of any country to the extent that the Member is entitled to coverage for such sickness or injury through any governmental plan or program except Medicaid.

8.25 Outpatient prescription drugs unless a supplemental benefits rider is attached hereto, and other drugs or medications except when provided to Member in an inpatient setting.

8.26 Hospital or Physician services or treatment provided as a result of a court order unless Preauthorization has been obtained from UnitedHealthcare.

8.27 Charges incurred in connection with (a) any testing or procedure to support a diagnosis of infertility; or (b) any assisted reproduction techniques, regardless of the reason for treatment, such as, but not limited to, artificial insemination and in vitro fertilization, donor services, reversal of vasectomies, reversal of tubal ligations or the reversal of other voluntary sterilization procedures.

8.28 Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

8.29 Cryopreservation and other forms of preservation of reproductive materials, regardless of the reason for preserving the materials.

8.30 Any treatment or procedures related to the performance of gender transformation.

8.31 Surgery to the cornea or any other part of the eye to improve vision by changing the refraction, such as but not limited to radial keratotomy or LASIK (laser assisted in-situ keratomileusis).

8.32 Physical exams and any related diagnostic testing required for employment, licensing, insurance, adoption, immigration, school, camp or sports participation when services will result in duplication of

UnitedHealthcare benefits for preventive care. Immunizations for the purpose of obtaining or maintaining employment are also excluded.

8.33 Any fees relating to any types of services or items resulting from an injury sustained as a result of the injury was the Member's commission of, or attempt to commit, a felony.

8.34 Performance of an injection by a nurse or Physician which would normally be self-administered, except in an inpatient setting.

8.35 Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy.

8.36 Surgical treatment and associated care for treatment of obesity.

8.37 Organ and tissue transplant services provided by Participating Providers that are not UnitedHealthcare-approved transplant centers or by Non-Participating Providers. Charges associated with more than one transplant center waiting list are also excluded. Organ and tissue transplant services are payable only as described in section 5.13.

8.38 Telephone or email consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for copying medical records.

8.39 Charges for non-used medication.

8.40 Replacement of items that are lost, stolen, misused, otherwise abused, or damaged due to neglect or accident.

8.41 Charges in excess of any Maximum Policy Benefit amount shown in Attachment D for any Member.

8.42 Charges in excess of any benefit maximum or limitation shown in Attachment D.

8.43 The following mental health and substance abuse services:

8.43.1 services, other than diagnostic services, for mental retardation or for non-treatable mental deficiency;

8.43.2 treatment of a mental or nervous disorder which is not subject to favorable modification by accepted psychiatric treatment;

8.43.3 treatment of marital problems;

8.43.4 family therapy, except as related to a Covered Service for another family member;

8.43.5 treatment of learning problems;

8.43.6 treatment of adult or childhood antisocial behavior without manifestation of a psychiatric disorder;

8.43.7 treatment of aggressive or nonaggressive conduct disorder without manifestation of a psychiatric disorder;

8.43.8 general counseling and advice;

8.43.9 charges for personal and convenience items such as telephone, television, personal care items and personal services or for charges for diversional activities such as recreational, hobby or craft equipment or fees; and

8.43.10 court ordered psychiatric services unless Preauthorization has been obtained from the mental health and/or substance abuse treatment program provider and/or UnitedHealthcare.

8.44 Services provided to a Member as part of a demonstration project conducted or sponsored by the Centers for Medicare & Medicaid Services (CMS).

8.45 The following spinal manipulative services:

Acupressure, acupuncture, arch supports, biosoterometric studies, cervical pillow, chelation therapy, colonic therapy or irrigations, computerized axial tomography, durable medical equipment, graphic x-ray analysis, hair analysis, hand held doppler, heavy metal screening, iridology, iris analysis, kinesiology, living cell analysis, magnetic resonance imaging, maintenance care, mineral cellular analysis, moiré contourographic analysis, nutritional counseling, nutritional supplements, over-the-counter drugs or preparations, oxygen therapy, Ream's lab or Ream's test, rolfing, sublingual or oral therapy, thermographic procedures, or toxic metal analysis.

ARTICLE 9 - GENERAL CONDITIONS UNDER WHICH BENEFITS SHALL BE PROVIDED

9.1 The benefits of this Contract are subject to all terms and conditions described herein.

9.2 Under this Contract, UnitedHealthcare has the right to make any benefit payment to the Provider of Covered Services, or directly to the Member. UnitedHealthcare is specifically authorized by the Member to determine to whom any benefit payment should be made. In the event a Member has to pay a Non-Participating Provider for Covered Service, at the time services are rendered, UnitedHealthcare will send payment for Covered Service to the Member in accordance with section 11.3, less any applicable Copayment, Coinsurance, Deductible, and/or Penalty amount

9.3 Hospital Services are subject to all the rules and regulations of the Hospital or Skilled Nursing Facility, including the rules and regulations governing admission and discharge.

9.4 The Member agrees that any complaint regarding this Contract or the provision of benefits under this Contract shall be submitted for resolution in accordance with the Member Complaint, Appeal, and Dispute Resolution Procedure established by UnitedHealthcare as set forth in Article 17.

9.5 In the event of fraud or misrepresentation of a material fact in enrolling or making claim for benefits under this Certificate of Coverage, including but not limited to the unauthorized use of a Member's UnitedHealthcare identification card by any other person, UnitedHealthcare shall have the right to recover the full amount of any benefits paid on behalf of the Member.

9.6 In the event of any major disaster or epidemic, war, riot or labor dispute, UnitedHealthcare shall provide coverage for Hospital Services and medical services covered under this Contract in so far as practical, according to its best judgment, within the limitations of such facilities and personnel as are then available. Under such conditions UnitedHealthcare shall not have any liability or obligation for delay or failure to provide coverage or arrange for Hospital Services or medical services due to lack of available facilities or personnel.

9.7 The Member agrees to provide UnitedHealthcare all information relating to duplicate insurance or other coverage for which there may be coordination of benefits.

ARTICLE 10 - RELATIONSHIP AMONG PARTIES AFFECTED BY THE CONTRACT

10.1 The relationship between UnitedHealthcare and any person or organization having a contract with UnitedHealthcare is an independent contractor relationship. No such organization or employee or agent thereof is an employee or agent of UnitedHealthcare, and neither is UnitedHealthcare nor any employee or agent of UnitedHealthcare an employee or agent of such organization.

10.2 Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services.

10.3 The Member is not an agent or representative of UnitedHealthcare, and shall not be liable for any acts or omissions of UnitedHealthcare, its agents or employees, or any other person or organization with which UnitedHealthcare has made or hereafter shall make arrangements for the performance of services under this Contract.

10.4 UnitedHealthcare has entered into a service agreement with its parent UnitedHealthcare Services Company of the River Valley, Inc. which. provides all administrative services for UnitedHealthcare.

ARTICLE 11 - CLAIM PROVISIONS

11.1 Except as set forth in Attachment D, it is not anticipated that a Member will make payment to any Participating Provider performing a Covered Service under this Contract beyond any applicable Copayment, Coinsurance, or Deductible. However, if the Member furnishes evidence satisfactory to UnitedHealthcare that he or she has made payment to a Participating Provider for performing a Covered Service under this Contract, payment for those charges will be made to the Member, but in no event will the amount of payment to the Member exceed the maximum benefit payable by UnitedHealthcare less any applicable Copayment, Coinsurance, or Deductible.

11.2 If a charge is made to a Member by a Participating Provider for performing a Covered Service under this Contract beyond any applicable Copayment, Coinsurance, or Deductible, written proof of such charges should be furnished to UnitedHealthcare within 90 days from the date of service. Payment for such charges will not be made to the Member if evidence of payment is submitted more than fifteen months after the date of service.

11.3 Charges for a Covered Service performed by a Non-Participating Provider will be paid to the Member, or to the Non-Participating Provider if there is a written assignment of benefits, after written proof of charges is furnished to UnitedHealthcare within 24 months from the date the service was performed. Payment for such charges will not be made to the Member, or to the Non-Participating Provider through a written assignment of benefits, if written proof of such charges is not furnished to UnitedHealthcare within this 24-month period.

ARTICLE 12 - PREMIUMS

12.1 Only Members for whom the Group has paid the Premium shall be entitled to benefits for the period for which such payment has been received. UnitedHealthcare will allow Group a grace period of 31 days following the Premium due date. This Contract shall stay in force during the grace period. If payment is not received before the end of the grace period, coverage will be terminated at the end of the grace period with prior notice to Group but without prior notice from UnitedHealthcare to Members, and Group and/or Members will be held liable for benefits received during the grace period.

12.2 The Group or its delegate is the plan administrator under federal law and is responsible for various duties as plan administrator including, but not limited to, notice to Members of suspension or termination of coverage and reporting and disclosure requirements. UnitedHealthcare is not the plan administrator. The Group, or its delegate, but not UnitedHealthcare, is responsible for complying with the health care continuation

provisions in the Consolidated Omnibus Budget Reconciliation Act of 1975 (COBRA), as amended, or any applicable state law.

ARTICLE 13 - TERMINATION

13.1 In addition to termination for non-payment of Premium as explained in section 12.1, UnitedHealthcare may terminate this Contract at any time for one or more of the following reasons:

13.1.1 Death of the Subscriber: Upon the death of the Subscriber this Contract shall automatically terminate. For coverage rights, if any, of surviving Eligible Dependents, see Article 14 and Article 15.

13.1.2 Subscriber no longer eligible: If the Subscriber is no longer eligible to participate in the health benefits plan offered by the Group under this Contract, this Contract shall automatically terminate. For coverage rights, if any, of Subscriber and Eligible Dependents, see Article 14 and Article 15.

13.1.3 Fraud or misrepresentation of a material fact in enrolling or making claim for benefits under this Contract: Under such circumstances, UnitedHealthcare shall have the right to recover the full amount of any benefits paid on behalf of the Member.

13.1.4 Unauthorized use of a Member's UnitedHealthcare identification card by any other persons: Under such circumstances, UnitedHealthcare may retain the identification card and all rights of such Member and, if such Member is a Subscriber, all rights of his or her Eligible Dependents shall terminate.

13.1.5 Change in status as Eligible Dependent: If a Member is no longer within the definition of an Eligible Dependent, his or her benefits shall terminate. For coverage rights, if any, see Article 14 and Article 15.

13.1.6 Failure on the Member’s part to pay Copayments, Coinsurance, Deductibles, or Penalty amounts.

13.1.7 Member engages in activities which endanger the safety and welfare of UnitedHealthcare or its employees or providers.

13.1.8 Expiration of the maximum continuation of coverage period as described in Article 14.

13.1.9 Such other reasons as may be approved by the appropriate regulatory agencies of the state of operation.

13.2 If the Group Health Contract which covers the Member terminates, this Contract shall terminate at the same time. If required by law, UnitedHealthcare shall give Member written notice prior to termination.

13.3 Upon termination of enrollment as provided in this Article or Article 12, Member shall cease to be entitled to any benefits under this Contract. However, if Member remains as an inpatient in a Hospital, Skilled Nursing Facility, or inpatient rehabilitation facility at the time of such termination, Member shall be entitled to an extension of benefits, subject to the terms and conditions of this Contract, for the treatment of the condition that has caused the confinement. Such an extension of benefits for Hospital, Skilled Nursing Facility, or inpatient rehabilitation facility services shall cease with the earliest occurrence of one of the following events:

13.3.1 The date the Member is discharged from the Hospital, Skilled Nursing Facility, or inpatient rehabilitation facility;

13.3.2 The date the Member reaches any Maximum Policy Benefit that applies.

13.3.3 The date the Attending Physician determines that the inpatient stay is no longer necessary or appropriate.

13.3.4 The date the Member becomes covered under another group health plan;

13.4 Except as provided in this Article, UnitedHealthcare must renew this Contract at the option of the Group, unless:

13.4.1 The Group fails to pay Premiums or contributions in accordance with the terms of this Contract.

13.4.2 The Group performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the coverage or, with respect to coverage of a Member, fraud, or intentional misrepresentation by the Member or the Member's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, UnitedHealthcare has the right to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.

13.4.3 The Group violates participation or contribution rules.

13.4.4 UnitedHealthcare ceases to offer a particular type of health insurance coverage in such market in accordance with applicable state law. If UnitedHealthcare decides to discontinue such product that has been purchased by the Group, UnitedHealthcare will meet the following requirements:

13.4.4.1 Provide written notice to Group and each Subscriber covered under this Contract, of the discontinuation of such product at least 90 days before the discontinuation of coverage;

13.4.4.2 Offer to Group the option on a guaranteed basis to purchase any other health insurance coverage currently being offered by UnitedHealthcare in such market; and

13.4.4.3 In exercising the option to discontinue such product and in offering the option of coverage under section 13.4.5, UnitedHealthcare will act uniformly without regard to claims experience of those Groups or any health status-related factor relating to any Members who may become eligible for such coverage.

13.4.5 UnitedHealthcare elects to discontinue offering all health insurance coverage in the State of Tennessee. Health insurance coverage may be discontinued by UnitedHealthcare only in accordance with applicable state law and if:

13.4.5.1 UnitedHealthcare provides written notice to the Tennessee Department of Commerce and Insurance and to Group and each Subscriber covered under this Contract, at least 180 days prior to the discontinuation of coverage; and

13.4.5.2 All affected group health contracts issued or delivered for issuance in the State of Tennessee are discontinued and coverage is not renewed.

13.5 A certificate of creditable coverage will be provided in accordance with state and federal law. Also, a Member may request a certificate of creditable coverage by contacting UnitedHealthcare at the appropriate address or toll-free telephone number listed in Attachment C.

ARTICLE 14 - CONTINUATION OF COVERAGE

14.1 **Continuation Coverage Under Federal Law.** If benefits under this Contract terminate due to a loss of eligibility according to the eligibility requirements established by UnitedHealthcare, continuation of

coverage shall be provided if required under the terms and conditions of any applicable federal laws. Members should contact their Group's plan administrator to determine whether they are eligible to continue coverage under federal law.

14.2 **Continuation Coverage Under State Law.** In the event that a Member does not qualify for continuation of coverage under federal law, or if the Member does not elect coverage under federal law, the state of Tennessee requires that the following continuation coverage be available:

14.2.1 If a Member ceases to be covered under this Contract for any reason other than the termination of the Group policy in its entirety or the termination of an insured class of which the Member was a member, the Member shall be entitled to continue coverage at the same level of Group benefits for the remainder of the month in which termination occurred, plus the additional three months following the month of termination.

14.2.1.1 To qualify for continuation, the Member must have been continuously covered under the Group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination. The Member is required to make advance payment of the full Group Premium for continuation to the Group on or before the beginning of each month's coverage.

14.2.1.2 At the end of this period of continuation, the Member shall be entitled to have issued a policy of conversion coverage as described in Article XV.

14.2.2 Member shall not be entitled to state continuation coverage if the Member's termination under the Group policy occurred because:

14.2.2.1 the Member failed to pay any required Premium or contribution;

14.2.2.2 the Member is eligible for Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded); or

14.2.2.3 any discontinued Group coverage was replaced by similar group coverage within 31 days.

The continuation provisions in section 14.2 also apply to Eligible Dependents who are terminated from the Group's coverage because of divorce or the death of the Subscriber. If an Eligible Dependent becomes eligible for continuation under these conditions, he or she shall be entitled to have coverage continued for the remainder of the month in which termination occurred plus up to 15 additional months. Payment in full for this continuation coverage must be made in advance to the Group on or before the beginning of each month's coverage. Members whose Group coverage is terminated during pregnancy shall be entitled to have their coverage continued under the Group policy for the remainder of the month in which termination occurred plus a period of not less than six months after the pregnancy ends and not more than the end of the second three-month period following the three-month period in which the pregnancy ends.

This state mandated continuation privilege substitutes for a portion of the rights a Member may have under he Consolidated Omnibus Budget Reconciliation Act (COBRA). In the event the Member selects the state continuation privilege and, upon expiration, subsequently enrolls for coverage under COBRA, any time period that the Member spent enrolled under this state continuation provision shall be subtracted from the maximum time period required under COBRA.

The Member must contact the Group's plan administrator to determine whether Member is eligible for state continuation.

ARTICLE 15 - CONVERSION PRIVILEGE

15.1 If a Member ceases to be covered under this Contract for any reason other than those described in section 15.2.1, the Member is entitled to have issued to him or her, without evidence of insurability, an individual or family conversion policy. UnitedHealthcare may require Copayments, Coinsurance or Deductibles under the conversion policy that are different than those under the Group policy. Information regarding conversion coverage options will be provided by the local UnitedHealthcare office at the request of the Enrollee. Written application for a conversion policy must be made and the first premium paid to UnitedHealthcare within 31 days after the loss of Group coverage. The effective date of the conversion policy shall be the day following the termination of coverage under the Group policy.

15.2 A conversion policy shall not be made available to a Member whose coverage terminates under the Group policy if:

15.2.1 Member's termination under the Group policy occurred because:

15.2.1.1 the Member failed to pay any required Premium or contribution;

15.2.1.2 the Member is eligible for Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965, or as later amended or superseded); or

15.2.1.3 any discontinued Group coverage was replaced by similar group coverage within 31 days.

15.2.2 Member is covered by or eligible for Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965, or as later amended or superseded);

15.2.3 Member is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical services subscriber contract or medical practice or other prepayment plan or by any other plan or program;

15.2.4 Member is covered by or eligible for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;

15.2.5 Member is covered by or eligible for similar benefits, pursuant to or in accordance with the requirements of any state or federal law; or

15.2.6 The benefit provided under section 15.2.3 or benefits provided or available under sections 15.2.4 and 15.2.5, together with the benefits provided by the conversion policy, would result in overinsurance according to UnitedHealthcare's standards.

15.3 Effective date of the conversion contract will be on the date of termination from the Group Health Contract.

ARTICLE 16 - REINSTATEMENT AND MISCELLANEOUS PROVISIONS

16.1 Any Contract which is terminated in any manner as provided herein may be reinstated by UnitedHealthcare at its sole discretion.

16.2 This Contract is personal to the Member and shall not be assigned, delegated, or transferred.

16.3 Applicants for enrollment shall complete and submit to UnitedHealthcare such applications, medical review questionnaires, or other forms or statements as UnitedHealthcare may reasonably request. Applicants agree

that all information contained in such materials shall be true, correct and complete to the best of their knowledge and belief.

16.4 Members may request additional identification cards, free of charge, by contacting UnitedHealthcare at the toll-free telephone number listed in Attachment C. Any cards issued by UnitedHealthcare to Members pursuant to this Contract are for identification only. Possession of a UnitedHealthcare identification card confers no right to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Contract have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to the provisions of this Contract shall be charged at prevailing rates.

16.5 UnitedHealthcare may receive rebates from pharmaceutical manufacturers. Rebates are the exclusive property of UnitedHealthcare and will not be considered when determining a Member's cost-sharing obligations, such as any applicable Copayment, Coinsurance, or Deductible.

16.6 UnitedHealthcare may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract.

16.7 **Entire Contract; Changes.**

16.7.1 This Contract constitutes the entire Contract between the parties and, as of the effective date hereof, supersedes all other agreements, oral or otherwise, between the parties regarding the subject matter of this Contract and may not be altered or amended except in writing.

16.7.2 No agent or other person, except an officer of UnitedHealthcare, has authority to waive any conditions or restrictions of this Contract; to extend the time for making a payment; or to bind UnitedHealthcare by making any promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless evidenced by an endorsement on it signed by one of the aforesaid officers, or by an amendment to it signed by the Group and by one of the aforesaid officers, and filed with the Tennessee Department of Commerce and Insurance or other appropriate regulatory agencies of the state of operation.

16.8 By electing coverage pursuant to this Contract, or accepting benefits under this Contract, all Members and their applicable legal representatives expressly agree to all terms, conditions and provisions of this Contract.

16.9 **Legal Actions.** No civil action shall be brought to recover on this Contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Contract. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

ARTICLE 17 - MEMBER COMPLAINT, APPEAL, AND DISPUTE RESOLUTION PROCEDURES

17.1 This Article sets forth a formal system for resolving Complaints and Appeals by Members concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare.

17.2 The following definitions apply to this Article XVII:

17.2.1 **Appeal** – a Complaint, which having been reported to UnitedHealthcare by the Member and remaining unresolved to the Member's satisfaction, is filed for formal proceedings as set forth in this Article XIV.

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

17.2.3 **Complaint** - an oral or written expression of dissatisfaction or a problem relating to the policies or the services provided by UnitedHealthcare.

17.3 Most Complaints can be resolved satisfactorily on an informal basis by consultation between the Member, UnitedHealthcare staff, and/or the health care practitioner from whom the Member has received services. If the Member has questions about a provider, coverage or services provided, he or she is encouraged to call a UnitedHealthcare Customer Service Representative (CSR). The phone number and address are provided in Attachment C. The CSR may forward the call to appropriate UnitedHealthcare personnel who can assist the Member.

17.4 If a Member's Complaint is not resolved through informal consultation, the Member or Member's Authorized Representative may request a formal Appeal using the procedures described below. If the Member wants to designate an Authorized Representative to assist him or her with this Appeal Process, this must be done in writing. A Member's Authorized Representative may not file a formal Appeal without explicit, written designation by the Member. The expedited appeal procedure is reserved for cases in which the Standard Member Appeal procedure will cause delay in rendering of health care that could: 1) seriously jeopardize the life or health of the Member or his or her ability to regain maximum function, or 2) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is subject to the Appeal. If the inquiry is related to a denial of coverage, UnitedHealthcare will provide the Member the procedures for filing an Appeal and his or her right to seek review by the Insurance Commissioner.

17.5 ***Expedited Member Appeal Procedure:*** To initiate an expedited Appeal, the Member or Member's Authorized Representative must contact a CSR, orally or in writing, with a request for an expedited review of the Member's Appeal. The request will be forwarded to the Vice President, Medical Management or designee for review.

17.5.1 In determining whether a claim is urgent and qualifies for expedited review, UnitedHealthcare will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

17.5.1.1 The request for expedited consideration will not be denied if a Physician with knowledge of the Member's medical condition determines that a claim involves urgent care.

17.5.1.2 If the request for expedited consideration is denied, the Member's or Member's Authorized Representative's Appeal will be automatically reviewed by UnitedHealthcare according to the Appeal Procedure of section 17.6.

17.5.2 Within 72 hours after UnitedHealthcare has received a request for expedited handling which includes all necessary information, UnitedHealthcare will issue a decision to the Member or Member's Authorized Representative by telephone or fax. If additional information is needed by UnitedHealthcare to review the expedited Appeal, the Member or Member's Authorized Representative will be notified within 24 hours of receipt of the expedited Appeal specifying the information needed by UnitedHealthcare to make a decision. When the additional information is received by UnitedHealthcare, a final decision will be made within 48 hours of receipt of the specified information or at the end of the period given to provide the specified information, whichever is earlier.

17.5.3 Written confirmation of the decision will be mailed to the Member or Authorized Representative within three calendar days. The notification will contain: 1) a statement of the Vice President, Medical Management or designee's understanding of the Member's Appeal; 2) the decision of the Vice President, Medical Management or his/her designee in clear terms; and; 3) a reference to the documentation and information used as the basis for the decision.

17.5.4 If the decision is not in the Member's favor, the Member or Member's Authorized Representative has 30 calendar days from receipt of UnitedHealthcare's decision to: 1) request, in writing, Appeal reconsideration from UnitedHealthcare pursuant to section 17.7; or, 2) request a review by the Insurance Commissioner or his/her designee.

17.6 ***Standard Member Appeal Procedure:*** To initiate an Appeal, the Member or Member's Authorized Representative may file a written "Appeal Form," which shall be provided by UnitedHealthcare upon the written or oral request of the Member or Member's Authorized Representative. The Appeal Form must be completed and filed to UnitedHealthcare within 180 days from the date: (1) the Member received notification of a denial of coverage; or (2) the problem in question occurred. This timeframe may be extended if extenuating circumstances have occurred that would allow additional time to file the Appeal. The Appeal Form shall be completed and signed by the Member or Member's Authorized Representative and the facts as alleged shall be binding on Member. The Appeal Form shall be filed by mail, fax, or hand-delivery to UnitedHealthcare, per the instructions provided with the Member Appeal Form.

17.6.1 Upon receipt of the Appeal, UnitedHealthcare shall issue a written acknowledgment to the Member or Member's Authorized Representative. The acknowledgment will include the name, address and telephone number of the person designated by UnitedHealthcare to coordinate the Appeal review.

17.6.2 The Appeal shall be forwarded to the Appeal/Reconsideration Committee established by UnitedHealthcare. The Appeal/Reconsideration Committee will not include a person whose decision is being appealed or who made the initial determination denying a claim or handling an Appeal. The Appeal/Reconsideration Committee will hold its review within ten business days of receipt of the Appeal Form.

17.6.3 A written decision will be mailed to the Member or Member's Authorized Representative within ten business days after receipt of an Appeal Form. The decision shall include: 1) a statement of the Appeal/Reconsideration Committee's understanding of the Member's Appeal; 2) the Committee's decision in clear terms; and 3) a reference to the documentation and information used as the basis for the decision.

17.6.4 If the Appeal/Reconsideration Committee's decision is not in the Member's favor, the Member or Member's Authorized Representative has 30 calendar days from receipt of the Appeal/Reconsideration Committee's decision to: 1) request in writing that UnitedHealthcare reconsider its Appeal decision (see section 17.7); or 2) request a review by the Insurance Commissioner or his/her designee.

17.7 ***Appeal Reconsideration Request***: If the Member or Member's Authorized Representative is not satisfied with the outcome of the Appeal review by UnitedHealthcare, the Member or Member's Authorized Representative can request in writing a reconsideration by the Appeal/Reconsideration Committee.

17.7.1 The Member or Member's Authorized Representative shall submit to UnitedHealthcare material pertinent to the reconsideration. The Appeal/Reconsideration Committee shall hold a review within ten business days of the receipt of the request for reconsideration. A written decision will be mailed to the Member or Member's Authorized Representative within ten business days after receipt of an Appeal Reconsideration Request. The written decision will inform the Member of his or her right to initiate a review by the Insurance Commissioner's office within 30 days of the Committee's reconsideration decision.

17.8 After exhausting the Appeal and reconsideration procedures described above, if the Member remains dissatisfied, he or she may**:**

17.8.1 bring a civil action in accordance with the rights and limitations of applicable law. If Group is

subject to the Employee Retirement Income and Security Act (ERISA), Member may exercise his or her right to bring a civil action under section 502(a) of ERISA.

17.9 Upon written request and free of charge, the Member or Member's Authorized Representative may request copies of all documents relevant to an Appeal or reconsideration.

17.10 By initiating an Appeal, reconsideration of an Appeal, or a complaint to the Tennessee Department of Commerce and Insurance ("Department"), Member consents to release of Member's medical records for all purposes related to that Appeal, reconsideration of an Appeal, or Department complaint.

17.11 Filing a Complaint or Appeal with UnitedHealthcare shall not preclude the Member from filing a formal complaint with the Tennessee Department of Commerce and Insurance ("Department"). Neither shall it preclude the Department from investigating a formal complaint pursuant to its authority.

17.12 For further information, the Member may contact UnitedHealthcare or the Tennessee Department of Commerce and Insurance at the address provided in Attachment C.

ARTICLE 18 - NOTICE

18.1 Any notice given by UnitedHealthcare to the Member shall be sufficient if mailed to the Member at his or her address as it appears on the records of UnitedHealthcare. It is the Member's responsibility to notify the personnel department of his or her Group of any and all changes in address. Any notice shall be deemed delivered when deposited in the United States mail at any post office or postal box with first class postage prepaid.

ARTICLE 19 - RIGHT OF SUBROGRATION AND REIMBURSEMENT

19.1 **Subrogation.** In the event of any payment of benefits for which a Member may have a claim or cause of action against any person or organization, UnitedHealthcare shall be subrogated to all right of recovery of the Member with respect to any judgment, payment or settlement for personal injury. The Member agrees as follows:

19.1.1 To fully cooperate with UnitedHealthcare in obtaining information about the loss and its cause;

19.1.2 To notify UnitedHealthcare of any claim for damages made or lawsuit filed on behalf of the Member in connection with the loss;

19.1.3 To include the amount of the benefits paid by UnitedHealthcare on behalf of the Member in claims for damages against other parties;

19.1.4 To notify UnitedHealthcare of a proposed settlement at least 30 days before any claim or lawsuit is settled in regard to the loss;

19.1.5 To provide UnitedHealthcare with a lien, to the extent of the cash value of these services and supplies provided. Such lien may be filed with the person whose act caused the injuries, his or her agent or a court having jurisdiction in the matter;

19.1.6 To pay UnitedHealthcare all costs and expenses, including attorney's fees, which were incurred or expended by UnitedHealthcare in obtaining or attempting to obtain payment from Member if he or she fails or refuses to reimburse UnitedHealthcare pursuant to this provision; and

19.1.7 To permit UnitedHealthcare to file a lawsuit in the name of the Member against the person whose act caused the injuries.

19.2 **Right of Reimbursement.** If a Member incurs expenses for sickness or injury that occurred due to the negligence of a third party: (a) UnitedHealthcare has the right to reimbursement for all benefits UnitedHealthcare paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Member, Member's parents, if the Member is a minor, or Member's legal representative as a result of that sickness or injury; and (b) UnitedHealthcare is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits UnitedHealthcare paid for that sickness or injury.

19.2.1 If UnitedHealthcare is the primary plan,UnitedHealthcare shall have the right to first reimbursement out of all funds the Member, the Member's parents, if the Member is a minor, or the Member's legal representative, is or was able to obtain for the same expenses UnitedHealthcare has paid as a result of that sickness or injury.

19.2.2 Member is required to furnish any information or assistance or provide any documents that UnitedHealthcare may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

ARTICLE 20 - COORDINATION OF BENEFITS

Coordination of Benefits with This Plan and Other Coverage

20.1 **Applicability.**

20.1.1 This COB provision does not apply to any supplemental benefits rider for prescription drugs under This Plan.

20.1.2 This Coordination of Benefits (COB) provision applies to This Plan when a Member has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

20.1.3 If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

20.1.3.1 shall not be coordinated when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

20.1.3.2 may be coordinated when, under the order of benefit determination rules, another Plan determines its benefits first. The above coordination is described in section 20.4, Effects on the Benefits of This Plan.

20.2 **Definitions.**

20.2.1 "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

20.2.1.1 Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

20.2.1.2 Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also

does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program.

Each contract or other arrangement for coverage under section 20.2.1.1 or 20.2.1.2 is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

20.2.2 "This Plan" is the part of the Group Health Contract that provides benefits for health care expenses.

20.2.3 "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

20.2.4 "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, subject to the terms and conditions of this Contract, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. This Plan shall not have payment liability as secondary carrier for charges not covered under this Contract unless the Member has established a credit within the Coordination of Benefits reserve bank.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

20.2.5 "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

20.3 **Order of Benefit Determination Rules.**

20.3.1 **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

20.3.1.1 the other Plan has rules coordinating its benefits with those of This Plan; and

20.3.1.2 both those rules and This Plan's rules, in section 20.3.2 below, require that This Plan's benefits be determined before those of the other Plan.

20.3.2 **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

20.3.2.1 Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or Subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

20.3.2.2 Dependent Child/Parents Not Separated or Divorced. Except as stated in section 20.3.2.3 below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

20.3.2.2.1 the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but

20.3.2.2.2 if both parents have the same birthday, the benefits of the Plan which has covered the parent longer are determined before those of the Plan which has covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in section 20.3.2.2.1 above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

20.3.2.3 Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

20.3.2.3.1 first, the Plan of the parent with custody of the child;

20.3.2.3.2 then, the Plan of the spouse of the parent with the custody of the child, and

20.3.2.3.3 finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of the parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

20.3.2.4 Active/Inactive Employees. The benefits of the Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 20.3.2.4 is ignored.

20.3.2.5 Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or Subscriber longer are determined before those of the Plan which covered that person for the shorter time.

20.4 **Effects on the Benefits of This Plan.**

20.4.1 **When This Section Applies.** This section 20.4 applies when, in accordance with section 20.3, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be coordinated under this section. Such other Plan or Plans are referred to as "the other Plans" in 20.4.2 below.

20.4.2 **Coordination in this Plan's Benefits.** The benefits of This Plan will be coordinated when the sum of:

20.4.2.1 the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

20.4.2.2 the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be coordinated so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are coordinated as described above, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of This Plan.

20.5 **Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. UnitedHealthcare has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. UnitedHealthcare need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts it needs to pay the claim.

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

20.7 **Right of Recovery.** If the amount of the payments made by UnitedHealthcare is more than it should have paid under this COB provision, it may recover the excess from one or more of:

20.7.1 the persons it has paid or for whom it has paid;

20.7.2 insurance companies; or

20.7.3 other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

20.8 **Worker's Compensation/Government Programs.** The order of primary responsibility stated above shall not apply when the Member is entitled to receive health care services or indemnity benefits (a) under Worker's Compensation or similar law, or (b) in a Hospital or facility owned or operated by any government agency. In such case, the primary responsibility shall rest with those persons or agencies having the obligation to provide the health care services or indemnity benefits under (a) or (b) above.

ARTICLE 21 - DISCRETIONARY AUTHORITY OF UNITEDHEALTHCARE

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

UnitedHealthcare Insurance Company of the River Valley

ATTACHMENT A

Contract Period - The period commencing on September 01, 2012 and ending August 31, 2013, and each 12-month period thereafter unless otherwise terminated as provided in the Article titled "Termination."

Annual Enrollment Period, as used in this attachment, means the designated period during which those persons meeting the eligibility requirements of UnitedHealthcare may enroll in UnitedHealthcare.

Late Member, as used in this attachment, is any Member who did not join UnitedHealthcare when first eligible for coverage and who did not qualify for special enrollment as described in Article 2 of this Contract.

Eligible individuals who do not elect UnitedHealthcare coverage during an Annual Enrollment Period are considered Late Members.

UnitedHealthcare Insurance Company of the River Valley

Attachment B

To participate under this Contract as a Subscriber, an individual must:

1) Be an Employee of the Group on a full-time basis, with a normal work week of at least 30 hours, or (if Group has elected to cover retirees) be a retiree who has been continuously enrolled in Group's health coverage plan since retirement; and,

2) Be entitled on his or her own behalf and not as an Eligible Dependent to receive benefits hereunder.

To participate under this contract as an Eligible Dependent, an individual must be one of the following persons:

1) The Subscriber's legal spouse.

2) The Subscriber's unmarried child who is under age 26 and primarily dependent upon the Subscriber for maintenance and support, and not working full-time. Coverage terminates on the last day of the month in which the child reaches age 26.

3) The Subscriber's unmarried child, regardless of age, who is all of the following:

   a) permanently and totally disabled, if the disability occurred while an Eligible Dependent as defined in 2) above;

   b) incapable of self-sustaining employment; and

   c) chiefly dependent upon the Subscriber or other care providers for support.

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

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

UnitedHealthcare Insurance Company of the River Valley

ATTACHMENT C

Enrollees with a complaint or appeal may reach UnitedHealthcare at the following address and/or phone number:

UnitedHealthcare Insurance Company of the River Valley
7213 Noah Reid Road, Suite 102
Chattanooga, TN 37421
(800) 224-6602

and

UnitedHealthcare Insurance Company of the River Valley
3800 Avenue of the Cities, Suite 200
Moline, Illinois 61265
(800) 747-1446
(800) 884-4327 TDD

If you would like to file a complaint with the Tennessee Department of Commerce and Insurance, they can be reached at the following address:

Tennessee Department of Commerce and Insurance
Attn: Consumer Insurance Services
500 James Robertson Parkway
Nashville, Tennessee 37243-1130
(615) 741-2218 or (800) 342-4029

UnitedHealthcare Insurance Company of the River Valley
Attachment D - Schedule of Benefits

Please refer to your Provider Directory for listings of Participating Physicians, Hospitals, and other Providers.

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Deductible (calendar year)		
Individual	$1,000	$2,000
Family	$2,000	$4,000
(The In-Network Deductible and Out-of-Network Deductible are separate.) All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.		
Maximum Out-of-Pocket Expense (calendar year) (includes Copayments, Coinsurance, and Deductibles)		
Individual	$2,000	$4,000
Family	$4,000	$8,000
(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate.) All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.		
Maximum Policy Benefit per Member	Unlimited	
(Plan pays a maximum benefit which includes both In-Network and Out-of-Network.)		
4th Quarter Deductible Carryover	Applicable	Applicable

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Preventive Care Services *("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)*		
Physical Exams/Well-Child Care	$0 Copayment per visit. Deductible does not apply.	40% of Allowed Charge for children newborn through 6 years of age. Services not covered for children age 7 years and up. Deductible does not apply.
Immunizations	0% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge for children newborn through 6 years of age. Services not covered for children age 7 years and up. Deductible does not apply.
Laboratory and X-ray	0% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge for children newborn through 6 years of age. Services not covered for children age 7 years and up. Deductible does not apply.
Physician Office Services		
Office Visits	$30 Copayment per visit. Deductible does not apply	40% of Allowed Charge after Deductible
Office Surgery	$30 Copayment per surgery. Deductible does not apply	40% of Allowed Charge after Deductible
Allergy Testing	$30 Copayment per visit. Deductible does not apply	Not Covered
Allergy Injections	20% of Allowed Charge. Deductible does not apply.	Not Covered
Other Injections	20% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
Maternity Physician Services	$300 Copayment per Pregnancy. Deductible does not apply.	40% of Allowed Charge after Deductible
Newborn Services		
Inpatient	*See "Physician Services at a Facility other than the Office" and "Facility Services."*	
Outpatient	*See "Physician Office Services"*	
Physician Services at a Facility other than the Office		
Home Visits	$30 Copayment per visit. Deductible does not apply	40% of Allowed Charge after Deductible
Inpatient Facility Visits	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility Visits	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Surgery	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Surgery	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Emergency Services	*(Follow-up care obtained in the emergency room is not covered.)*	
Emergency Room Physician	0% of Allowed Charge. Deductible does not apply.	0% of Allowed Charge. Deductible does not apply.
Emergency Room	$100 Copayment per visit for a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.	$100 Copayment per visit for a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.
	Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.	
Urgent Care Facility	$30 Copayment per visit. Deductible does not apply	40% of Allowed Charge after Deductible
Ambulance Services	20% of Allowed Charge after Deductible	20% of Allowed Charge after Deductible
	Non-emergency transports must be approved in advance by UnitedHealthcare.	
Laboratory and X-ray Services		
Outpatient	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office	0% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
	Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.	
Chemotherapy, Radiation Therapy, Renal Dialysis Services		
Hospital (Outpatient)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office	20% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
Facility Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Skilled Nursing Facility (2) - (*Limited to 100 Skilled Nursing Facility days per calendar year) (The In-Network and Out-of-Network days are combined.)*	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Medical Equipment		
Durable Medical Equipment (2)	20% of Allowed Charge after Deductible	Not Covered
Prosthetic Devices (2)	20% of Allowed Charge after Deductible	Not Covered
Hearing Aid Devices (2) (Plan pays a maximum benefit of $5,000 per calendar year)	20% of Allowed Charge after Deductible	Not Covered
Outpatient Rehabilitative Therapy (*Limited to 60 visits per calendar year) (The In-Network and Out-of-Network visits are combined.)*	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.		
Spinal Manipulative Services	$30 Copayment per visit. Deductible does not apply	40% of Allowed Charge after Deductible
Home Health Services (2)	20% of Allowed Charge after Deductible	Not Covered
Hospice (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Respite Care (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Organ and Tissue Transplants (2)	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	**Not covered**
Cornea Transplants	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	
Mental Health Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Physician Services (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office Visits	$30 Copayment per visit. Deductible does not apply	40% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Physician Services (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office Visits	$30 Copayment per visit. Deductible does not apply	40% of Allowed Charge after Deductible

Coverage Limitations

(1) For services from Non-Participating Providers, the Allowed Charge is the Maximum Allowance. Except when services were rendered in a Medical Emergency, the Member is responsible for paying any amounts exceeding the Maximum Allowance for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.

(2) Services require Preauthorization. When a Member uses Participating Providers, the Participating Provider is responsible for obtaining Preauthorization. When a Member uses Non-Participating Providers, the Member is responsible for obtaining Preauthorization from UnitedHealthcare (or for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider). If the Member fails to obtain Preauthorization for Covered Services from Non-Participating Providers, the Member will pay a Penalty of an additional 10 percentage points in his or her Out-of-Network Coinsurance. The Penalty amount paid by the Member will not exceed $1,000, and it will not count toward the Deductible or Maximum Out-of-Pocket Expense.

When multiple Covered Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered Service will apply. For example, a laboratory and x-ray service separately charged by an independent laboratory outside of the Physician's office has a separate Copayment, Coinsurance and/or Deductible in addition to the Physician's office Copayment, Coinsurance or Deductible.

UnitedHealthcare Insurance Company of the River Valley
SUPPLEMENTAL BENEFITS RIDER TO CERTIFICATE OF COVERAGE UNDER GROUP HEALTH CONTRACT

PRESCRIPTION DRUG PRODUCTS

This Prescription Drug Product Rider (Drug Rider) is subject to all provisions of the Certificate of Coverage under Group Health Contract (Certificate of Coverage) not in conflict with the provisions of this Drug Rider. In the event of such conflict, the provisions in this Drug Rider will govern coverage for Prescription Drug Products.

INTRODUCTION

COVERAGE POLICIES AND GUIDELINES

UnitedHealthcare Insurance Company of the River Valley's (UnitedHealthcare) Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of a U.S. Food and Drug Administration (FDA)-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety, or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

UnitedHealthcare may change the placement of a Prescription Drug Product among the tiers. These changes will occur no more than six (6) times per calendar year. These changes may occur without prior notice to the Member.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Members as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Member is a determination that is made by the Member and the prescribing physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Member may be required to pay more or less for that Prescription Drug Product. The Member may access www.uhcrivervalley.com through the Internet or call Customer Service at the telephone number on his or her ID card for the most up-to-date tier status.

DESIGNATED PHARMACIES

If the Member requires certain Prescription Drug Products, UnitedHealthcare may direct the Member to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Prescription Drug Products.

If the Member is directed to a Designated Pharmacy and the Member chooses not to obtain his or her Prescription Drug Product from a Designated Pharmacy, the Member will be subject to the non-network benefit for that Prescription Drug Product.

LIMITATION ON SELECTION OF PHARMACIES

If UnitedHealthcare determines that the Member may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, his or her selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require the Member to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Member uses the designated single Network Pharmacy. If

the Member doesn't make a selection within thirty-one (31) days of the date UnitedHealthcare notifies the Member, UnitedHealthcare will select a single Network Pharmacy for the Member.

REBATES AND OTHER PAYMENTS

UnitedHealthcare may receive rebates for certain drugs included on the Prescription Drug List. UnitedHealthcare does not pass these rebates on to the Member, nor are they taken into account in determining his or her Drug Copayments. UnitedHealthcare, and a number of UnitedHealthcare's affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Drug Rider. 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 Drug Rider. UnitedHealthcare is not required to pass on to the Member, and does not pass on to the Member, such amounts.

COUPONS, INCENTIVES AND OTHER COMMUNICATIONS

At various times, UnitedHealthcare may send mailings to the Member or his or her Attending Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable the Member, at his or her discretion, to purchase the described Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only the Member's physician can determine whether a change in his or her Prescription Order or Prescription Refill is appropriate for his or her medical condition.

SPECIAL PROGRAMS

UnitedHealthcare may have certain programs in which the Member may receive an enhanced or reduced benefit based on his or her actions, such as adherence/compliance to medication regimens. The Member may access information on these programs through the Internet at www.uhcrivervalley.com or by calling Customer Service at the telephone number on his or her ID card.

SPECIALTY PRESCRIPTION DRUG PRODUCTS

Benefits are provided for Specialty Prescription Drug Products.

If the Member requires Specialty Prescription Drug Products, UnitedHealthcare may direct him or her to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products.

If the Member is directed to a Designated Pharmacy and the Member chooses not to obtain his or her Specialty Prescription Drug Product from a Designated Pharmacy, the Member will be subject to the non-Network benefit for that Specialty Prescription Drug Product.

Please see *Definitions* for a full description of Specialty Prescription Drug Products and Designated Pharmacy.

Specialty Prescription Drug Products - The following supply limits apply.

> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
>
> When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31day supply, the Drug Copayment that applies will reflect the number of days dispensed.
>
> Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a Non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

COORDINATION OF BENEFITS

Coordination of Benefits does not apply to Prescription Drug Products covered through this Drug Rider. Prescription Drug Product benefits will not be coordinated with those of any other health coverage plan.

DEFINITIONS

Brand-Name Drug – a Prescription Drug Product: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Member should know that all Prescription Drug Products identified as "brand name" by the manufacturer, pharmacy, or theMember's physician may not be classified as Brand-Name Drugs by UnitedHealthcare.

Chemically Equivalent – when Prescription Drug Products contain the same active ingredient.

Co-Marketed Drug - equivalent Brand-Name Drug that contains the same active ingredient(s) and is available from more than one pharmaceutical company.

Compounded Prescription – a Prescription Drug Product that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the FDA and that contains at least one ingredient classified as a Prescription Drug Product.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Direct Member Reimbursement - the process whereby a Member pays for a Prescription Drug Product at a pharmacy and submits a receipt and claim form to UnitedHealthcare for reimbursement based on the Predominant Reimbursement Rate.

Drug Copayment - the amount the Member must pay for each Prescription Drug Product received. Each Drug Copayment shall be paid at the time the service is rendered.

Generic Drug – a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-Name Drug; or (2) that UnitedHealthcare identifies as a generic drug product based on available data resources, including, but not limited to First DataBank, that classify drugs as either brand or Generic Drug based on a number of factors. The Member should know that all Prescription Drug Products identified as a "generic drug" by the manufacturer, pharmacy, or his or her physician may not be classified as a Generic Drug by UnitedHealthcare.

Maximum Allowable Cost (MAC) List – a list of Generic Drugs that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

Network Pharmacy - a licensed pharmacy that has entered into a contractual agreement with UnitedHealthcare to dispense Prescription Drug Products to Members.

Non-Network Pharmacy - any licensed pharmacy that has not entered into a contractual arrangement with UnitedHealthcare to dispense Prescription Drug Products to Members.

Pharmaceutical Product(s) - FDA-approved prescription pharmaceutical products administered in connection with a Covered Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Certificate of Coverage.

Pharmacy Billed Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Pharmacy Billed Charge includes a dispensing fee and any applicable sales tax.

Predominant Reimbursement Rate – the amount UnitedHealthcare will pay to reimburse the Member for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using UnitedHealthcare's Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost – the rate UnitedHealthcare has agreed to pay UnitedHealthcare's Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List – a list that categorizes into tiers medications, products or devices that have been approved by the FDA. This list is subject to UnitedHealthcare's periodic review and modification. These changes will occur no more than six (6) times per calendar year. The Member may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcrivervalley.com or by calling Customer Service at the telephone number on his or her ID card.

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

Prescription Drug Product(s) - a medication product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Prescription Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under this Drug Rider, this definition includes:

Inhalers (with spacers);

Insulin.

The following diabetic supplies:

Standard insulin syringes with needles;

Blood-testing strips - glucose;

Urine-testing strips - glucose;

Ketene-testing strips and tablets;

Lancets and lancet devices; and

Glucose monitors.

Prescription Fill - the initial quantity of a Prescription Drug Product dispensed pursuant to a Prescription Order.

Prescription Order - authorization for the dispensing of a Prescription Drug Product, issued by an Attending Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Prescription Refill - a subsequent quantity of a Prescription Drug Product dispensed after the initial Prescription Fill.

90-Day Supply List - a listing of Prescription Drug Products that UnitedHealthcare has approved for coverage when obtained in quantities up to a 90-day supply. This list will be subject to periodic review and modification by UnitedHealthcare.

Specialty Prescription Drug Product – Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. The Member may access a complete list of Specialty Prescription Drug Products through the Internet at www.uhcrivervalley.com or by calling Customer Service at the telephone number on his or her ID card.

Therapeutically Equivalent – when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

COVERED DRUGS

To be covered under this Drug Rider, Prescription Drug Products must not be otherwise excluded in this Drug Rider or in the Certificate of Coverage.

Prescription Drug Products will be covered only for FDA-approved indications or for non-FDA-approved indications if such use is commonly accepted as a standard of care, as indicated by the following official compendia:

The AMA Drug Evaluations, The American Hospital Formulary Service Drug Information, or The United States Pharmacopoeia Dispensing Information.

DRUG COPAYMENTS

Drug Copayment for a Prescription Drug Product at a Network or Non-Network Pharmacy is a specific dollar amount.

The Member's Drug Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product.

For Prescription Drug Products at a retail Network Pharmacy, the Member is responsible for paying the lower of:

- The applicable Drug Copayment; or
- The Network Pharmacy's Pharmacy Billed Charges for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, the Member is responsible for paying the lower of:

- The applicable Drug Copayment; or
- The Prescription Drug Cost for that Prescription Drug Product.

Prescription Drug Products are subject to the following cost-sharing schedule:

Tier 1 - $10 Drug Copayment.

Tier 2 - $35 Drug Copayment.

Tier 3 - $60 Drug Copayment.

Drug Copayments do not apply towards the applicable Maximum Out of Pocket Expense, as shown in Attachment D to the Certificate of Coverage.

The Member's Drug Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product.

NOTE: The tier status of a Prescription Drug Product can change periodically based on the Prescription Drug List Management Committee's periodic tiering decisions. These changes will occur no more than six (6) times per calendar year. These changes may occur without prior notice to the Member. When that occurs, the Member may pay more or less for a Prescription Drug Product, depending on its tier assignment. The Member may access www.uhcrivervalley.com through the Internet or call Customer Service at the telephone number on his or her ID card for the most up-to-date tier status.

APPLICATION OF DRUG COPAYMENTS

The Member is responsible for one Drug Copayment for each 31-day supply or such other day supply as determined by UnitedHealthcare. Member may request up to a 90-day supply of Prescription Drug Products on the 90-Day Supply List. Member is responsible for two and a half Drug Copayment(s), for each 90-day supply Prescription Fill or Prescription Refill purchased at a retail pharmacy that has agreed to dispense a 90 day supply or by mail order.

If for any reason a Member utilizes a Non- Network Pharmacy to obtain a Prescription Drug Product, the Member will be required to pay the Pharmacy Billed Charge. The Member should contact UnitedHealthcare's Customer Service Department to obtain a Direct Member Reimbursement form. The Member must complete the form and submit it to UnitedHealthcare together with the pharmacy receipt to be considered for reimbursement. If UnitedHealthcare approves reimbursement, the Member will be responsible for the Drug Copayment plus the difference between the Pharmacy Billed Charge and UnitedHealthcare's Prescription Drug Cost.

IF A BRAND-NAME DRUG BECOMES AVAILABLE AS A GENERIC DRUG

If a Generic Drug becomes available for a Brand-Name Drug, the tier placement of the Brand-Name Drug may change, and therefore the Member's Drug Copayment may change. The Member will pay the Drug Copayment applicable for the tier to which the Prescription Drug Product is assigned.

LIMITATIONS

Prescription quantity shall be limited to the amount ordered by the Attending Physician for a specified course of treatment. Quantity per Prescription Fill or Prescription Refill shall not exceed a 31-day supply or such other day supply as authorized by UnitedHealthcare. However, Prescription Drug Products on the 90-Day Supply List may be dispensed in quantities up to a maximum of 90-day supply through a retail pharmacy that has agreed to dispense a 90 day supply or by mail order.

These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.*

A Member will be considered to have an adequate supply of medication from the previous dispensing date and will not be eligible for benefits under this Drug Rider if an insufficient number of days have elapsed between Prescription Fills or Prescription Refills as determined by UnitedHealthcare.

For contraceptives a one-cycle supply is allowed. However, the Member may obtain up to three (3) cycles at one time if the Member pays a Drug Copayment for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Drug Copayment that applies will reflect the number of days dispensed.

UnitedHealthcare reserves the right to limit the quantity dispensed per Prescription Fill or Prescription Refill and the frequency of Prescription Fills or Prescription Refills to those reasonable for a specified condition or episode or usual dosing frequency approved by the FDA.

UnitedHealthcare reserves the right to establish criteria and require prior authorization for new or currently available Prescription Drug Products.

NOTIFICATION REQUIREMENTS

Before certain Prescription Drug Products are dispensed to the Member, either the Member's physician, the Member's pharmacist, or the Member is required to notify UnitedHealthcare or UnitedHealthcare's designee. The reason for notifying UnitedHealthcare is to determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

· It meets the definition of "Medically Necessary" as described in the Certificate of Coverage.

· It is not otherwise excluded as experimental and/or investigational, or for any other reason, in the Certificate of Coverage or this Drug Rider.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or the Member is responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Non-Network Pharmacy, the Member or his or her physician is responsible for notifying UnitedHealthcare as required.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, the Member may pay more for that Prescription Order or Prescription Refill. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification. The Member may determine whether a particular Prescription Drug Product requires notification through the Internet at www.uhcrivervalley.com or by calling Customer Service at the telephone number on his or her ID card.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, the Member can ask UnitedHealthcare to consider reimbursement after the Member receives the Prescription Drug Product. The Member will be required to pay for the Prescription Drug Product at the pharmacy. UnitedHealthcare's contracted pharmacy reimbursement rates (UnitedHealthcare's Prescription Drug Cost) will not be available to the Member at a non-Network Pharmacy. The Member may seek reimbursement from us as described in the section *Application of Drug Copayments.*

When the Member submits a claim on this basis, the Member may pay more because he or she did not notify us before the Prescription Drug Product was dispensed. The amount the Member is reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a Non-Network Pharmacy), less the required Drug Copayment.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not covered.

STEP THERAPY

Certain Prescription Drug Products for which benefits are described under this Drug Rider or Pharmaceutical Products for which Benefits are described in the Member's Certificate of Coverage are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products or Pharmaceutical Products the Member is required to use a different treatment(s) and/or Prescription Drug Product(s) or Pharmaceutical Product(s) first.

The Member may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.uhcrivervalley.com by calling Customer Service at the telephone number on his or her ID card.

EXCLUSIONS

Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for emergency treatment.

A Pharmaceutical Product for which benefits are provided in the Member's Certificate of Coverage.

Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare determines are excluded under the Certificate of Coverage.

Experimental or investigational medications, medications used for experimental indications, and/or dosage regimens determined by UnitedHealthcare to be experimental.

Prescription Drug Products not included on Tier 1, Tier 2 or Tier 3 of the Prescription Drug List at the time the Prescription Order or Prescription Refill is dispensed.

New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by UnitedHealthcare's Prescription Drug List Management Committee.

Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

Drugs available over-the-counter that do not require a Prescription Order or Prescription Refill by federal or state law before being dispensed, unless UnitedHealthcare has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Prescription Refill from a physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that UnitedHealthcare has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six (6) times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

Drugs that are entirely consumed at the time and place of prescribing.

Drugs dispensed to a Member while an inpatient in a facility such as a hospital or similar institution when such institution dispenses and bills for medications used during confinement.

Medications dispensed by a facility other than a licensed pharmacy.

Charges for the administration or injection of any medication.

Injectable medications that are not typically self-administered by the Member. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Any type of therapeutic or prosthetic device, appliance, support, or hypodermic syringe (other than disposable syringes to inject insulin), even though such device, appliance, support, or syringe may require a prescription. Such items may be payable as Durable Medical Equipment as described in the Certificate of Coverage.

Replacement of lost, stolen, broken, or discarded medications.

Prescription Drug Products furnished by the local, state, or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare), whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, injury, sickness, or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Medications dispensed prior to the effective date or after the termination date of Member's coverage.

Medications that are abused or otherwise misused by the Member.

Medications prescribed for cosmetic purposes.

Medications used to enhance physical or mental performance (e.g., anabolic steroids) without a defined underlying pathological cause.

Prescription Drug Products in convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container.

Unit dose packaging of Prescription Drug Products.

Compounded Prescriptions that do not contain at least one ingredient that has been approved by the FDA and require a Prescription Order or Prescription Refill. Compounded Prescriptions that are available as a similar commercially available Prescription Drug Product. (Compounded Prescriptions that contain at least one ingredient that require a Prescription Order or Prescription Refill are assigned to Tier 3.)

Drugs used for the treatment of infertility.

Growth promoting substances, unless medically necessary.

Smoking deterrents, nicotine replacement products, medication, aids, treatment, or supplies for nicotine addiction or to promote smoking reduction or cessation.

Any medication for treatment of sexual dysfunction or impotence, or to improve sexual performance or functioning.

Any product dispensed for the purpose of appetite suppression or weight loss.

Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of sickness or injury, except as required by state mandate.

General vitamins, except the following, which require a Prescription Order or Prescription Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.

A Prescription Drug Product that contains (an) active ingredient(s) that is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Nondiscrimination Policy

UnitedHealthcare Insurance Company of the River Valley Enrollees have the right to receive services from the insurance company without discrimination due to age, sex, color, race, religion, or national origin. We encourage any Enrollee who feels discrimination has occurred to file a complaint in accordance with the UnitedHealthcare Insurance Company of the River Valley complaint/Appeal procedure. We are committed to seeing to it that our Enrollees are treated fairly.

Member Bill of Rights and Responsibilities

As a member of UnitedHealthcare Insurance Company of the River Valley, you have certain rights and responsibilities, which are outlined below.

Members have the right to:

1. Available and accessible service that can be secured as promptly as appropriate for the symptoms presented, in a manner that assures continuity, and, when medically necessary, the right to emergency services available 24 hours a day, 7 days a week.
2. Receive information regarding their health problems, treatment alternatives and associated risks sufficient to assure an informed choice.
3. Privacy of their medical and financial records, which will be maintained by the Plan and/or the Participating Provider in accordance with applicable law.
4. File a complaint and/or appeals according to the procedure as set forth in the appropriate benefit plan documents if they experience a problem with the Plan or any Participating Provider.
5. Be treated privately, with respect and dignity.
6. Participate in decisions regarding their health care.
7. Access his/her medical records in accordance with applicable law.
8. Be provided with information about the Plan, its services, the practitioners providing care, and members' rights and responsibilities.
9. Make recommendations regarding the Plan's members' rights and responsibilities policies.
10. A candid discussion with their Participating Provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
11. Be given information by the Plan about our financial arrangements with Participating Providers, including financial incentives based on the cost of services and quality of care.

Members are responsible for:

1. Reading the benefit plan documents and member materials in their entirety and complying with the rules and limitations as stated.
2. Contacting Participating Providers to arrange for medical appointments as necessary.
3. Notifying Participating Providers in a timely manner of any cancellation of appointments.
4. Paying the coinsurance and deductibles as stated in the benefit plan documents at the time service is provided.
5. Obtaining the necessary preauthorization for services when required.
6. Carrying and using their Plan identification card and identifying themselves as a Plan member prior to receiving medical services.
7. Providing, to the extent possible, information needed by professional staff in order to care for the member.
8. Understanding their health problems and participating in developing mutually agreed upon treatment goals to the degree possible.
9. Following plans and instructions for care that they have agreed on with those providing health care services.

Advance Medical Directives

UnitedHealthcare Insurance Company of the River Valley has been instructed by federal law to inform you about your rights under The Patient Self-Determination Act.

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

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

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

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

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

What is an Advance Directive?

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

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

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

If you are an adult and of "sound mind," you can make an advance directive.

There are two types of formal advance directives. You can complete either a Living Will, a Power of Attorney for Health Care, or both.

Living Will

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

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

The Power of Attorney for Health Care

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

Maintaining Your Advance Directive

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

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

Will All States Recognize My Directives?

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

Specific questions should be directed to your physician and/or attorney for guidance.