Summary Plan Description

State of Rhode Island
2014 Active Employees Health Plan
Choice Plus HSA

Effective: July 1, 2016
Group Number: 707837

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: 1-866-202-0434.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

State of Rhode Island is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

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

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan.

State of Rhode Island intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

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

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

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by visiting online at www.employeebenefits.ri.gov.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- State of Rhode Island is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

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

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 20 hours per week. An Eligible Person shall also include members of the General Assembly and excludes Clerks, Door Keepers and Pages.

Note: You are not eligible to enroll in the Plan if you are on an unpaid leave of absence from the workplace.

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

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and State of Rhode Island share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

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

Note: The Internal Revenue Service generally does not consider Domestic Partners eligible Dependents. Therefore, the value of State of Rhode Island's cost in covering a Domestic

Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner may be paid using after-tax payroll deductions.

Your contributions are subject to review and State of Rhode Island reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates online at www.employeebenefits.ri.gov or from your Human Resources office.

How to Enroll

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

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

Important
If you wish to change your benefit elections following the birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections. You have up to 60 days to report a marriage.

When Coverage Begins

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

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 60 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

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

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

Changing Your Coverage

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

- your marriage, divorce, legal separation or annulment (you must contact Human Resources within 60 days);
- registering a civil union, dissolution of a civil union;
- registering a Domestic Partner, dissolution of a Domestic Partnership;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse;
- when an employed family member changes a health election in a plan sponsored by his/her employer during their open enrollment period; or
- a court or administrative order.

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

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

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date of legal adoption.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in State of Rhode Island's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under State of Rhode Island's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

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

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

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

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of State of Rhode Island or UnitedHealthcare.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

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

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered

Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Facility or Designated Physician chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion. Please refer to *Travel and Lodging* in Section 6*, Additional Coverage Details* for further benefit information.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by UnitedHealthcare.

Limitations on Selection of Providers

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

Coverage While Traveling Abroad

The Plan pays Benefits for Covered Persons while traveling outside the United States. Eligible Expenses for non-Emergency services incurred while outside the United States are reimbursed at the non-Network benefit level. Emergency services received outside the United States will be paid at the network benefit level. If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, refer to Section 9, *Claims Procedures*. If you have any questions about Benefits while traveling abroad, please call UnitedHealthcare at the toll-free number on your ID card.

Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the

non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

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

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

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion. If rates have not been negotiated, then one of the following amounts:

- Eligible Expenses are determined based on 140% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
  - 50% of CMS for the same or similar laboratory service.
  - 45% of CMS for the same or similar Durable Medical Equipment, or CMS competitive bid rates.
- When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health*

Systems, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

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

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

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

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

Annual Deductible

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

Coinsurance

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

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

Out-of-Pocket Maximum

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

maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

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

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments, except for those Covered Health Services identified in the Section 5, *Plan Highlights* table that do not apply to the Out-of-Pocket Maximum	Yes	Yes
Charges for non-Covered Health Services	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:
- An overview of the Personal Health Support program.
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

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

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

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

and share important health care information related to the participant's specific chronic or complex condition.

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

Requirements for Notifying Personal Health Support

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

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services.

The services that require notification are:

- Ambulance - non-emergent air.
- Clinical Trials.
- Congenital heart disease surgery.
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes.
- Genetic testing - BRCA
- Home health care.
- Hospice care - inpatient.
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological Disorders - Autism Spectrum Disorders Services-inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- Newborn Care.
- Obesity surgery.

- Prosthetic Devices for items that will cost more than $1,000 to purchase or rent.
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Surgery - sleep apnea surgeries and orthognathic surgeries.
- Therapeutics - all outpatient therapeutics.
- Transplants.

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

For notification timeframes that apply if you do not notify the Claims Administrator or contact Personal Health Support, see Section 6*, Additional Coverage Details*.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

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

Plan Features	Network	Non-Network
Annual Deductible[1,2]		
■ Individual	$1,500	$2,250
■ Family (cumulative Annual Deductible[2])	$3,000	$4,500
Annual Out-of-Pocket Maximum[1,3]		
■ Individual	$3,000	$4,500
■ Family (cumulative Out-of-Pocket Maximum[3])	$6,000	$9,000
Lifetime Maximum Benefit[4]		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

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

[2]The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

[3]The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Ambulance Services See Section 6, *Additional Coverage Details*, for benefit information.		
■ Emergency Ambulance	90% after you meet the Annual Deductible	90% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance	90% after you meet the Annual Deductible	90% after you meet the Network Annual Deductible
Emergency/Non-Emergency Air and Water Transportation: Subject to Annual Deductible and Coinsurance up to a $3,000 Maximum Benefit per occurrence.		
Cancer Resource Services (CRS)[2] See Section 6, *Additional Coverage Details*, for benefit information.		
■ Hospital Inpatient Stay	90% after you meet the Annual Deductible	Not Covered
Clinical Trials See Section 6, *Additional Coverage Details*, for benefit information.		
Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Diabetes Services See Section 6, *Additional Coverage Details*, for benefit information. Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items ■ insulin pumps ■ diabetes supplies	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Early Intervention Services must be provided by a licensed provider designated by the Department of Human Services as an "early intervention provider" and who works in early intervention programs approved by the Department of Health See Section 6, *Additional Coverage Details*, for benefit information.	100% Deductible waived	100% Deductible waived

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Emergency Health Services - Outpatient See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Network Annual Deductible	
Enteral Nutrition Products See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hearing Aids See Section 6, *Additional Coverage Details*, for limits.	90%, up to $5,000 Calendar year maximum after you meet the Annual Deductible	70%, up to $5,000 Calendar year maximum after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Infertility Services See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Injections – Professionally Assisted	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only) See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Lab, X-Ray and Diagnostics - Outpatient See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lyme Disease Treatment See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Mental Health Services See Section 6, *Additional Coverage Details*, for benefit information.		
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorders Services See Section 6, *Additional Coverage Details*, for benefit information.		
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Newborn Care See Section 6, *Additional Coverage Details*, for benefit information.	90% Deductible waived	70% Deductible waived

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Nutritional Counseling See Section 6, *Additional Coverage Details* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery See Section 6, *Additional Coverage Details*, for benefit information.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Orthognathic Surgery See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Orthotic Devices See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Ostomy Supplies See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient See Section 6, *Additional Coverage Details*, for benefit information.		
■ Primary Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Specialist Physician	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient services received at a Hospital or Alternate Facility	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Physician's Office Services - Sickness and Injury No Copay applies when no Physician charge applies. Hospital based clinic visits are considered Office visits and are subject to the appropriate Office visit Copayment listed. See Section 6, *Additional Coverage Details*, for benefit information.		
■ Primary Physician	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Specialist Physician	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pregnancy – Maternity Services See Section 6, *Additional Coverage Details*, for benefit information.	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services See Section 6, *Additional Coverage Details*, for benefit information.		
■ Physician Office Services	100% Deductible waived	70% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests	100% Deductible waived	70% after you meet the Annual Deductible
■ Breast Pumps	100% Deductible waived	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Prosthetic Devices See Section 6, *Additional Coverage Details*, for benefit information.	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures See Section 6, *Additional Coverage Details*, for benefit information.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance Use Disorder Services See Section 6, *Additional Coverage Details*, for benefit information.		
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Surgery - Outpatient See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Temporomandibular Joint (TMJ) Services See Section 6, *Additional Coverage Details*, for benefit information.	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Tobacco Cessation Treatment – Outpatient See Section 6, *Additional Coverage Details*, for benefit information.	100% Deductible waived	70% after you meet the Annual Deductible
Transplantation Services See Section 6, *Additional Coverage Details*, for benefit information. Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Service category in this section.	
Travel and Lodging (If services rendered by a Designated Facility) See Section 6, *Additional Coverage Details*, for benefit information.	For patient and companion(s) of patient undergoing transplant procedures	
Treatment of Gender Dysphoria (Gender Identity Disorder)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Urgent Care Center Services (See Section 6, *Additional Coverage Details*, for benefit information.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Wigs See Section 6, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

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

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

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services for which you should notify Personal Health Support before you receive them.

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

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Ground Ambulance

Local professional or municipal ground ambulance services are covered when it is medically necessary to use these services, rather than any other form of transportation, to the following destinations:

- to the closest available Hospital for an inpatient admission;
- from a Hospital to home or to a Skilled Nursing Facility after being discharged as an inpatient;

- to the closest available Hospital emergency room immediately in an emergency; OR
- to and from a Hospital for medically necessary services not available in the Hospital where you are an inpatient.

Our allowance for the ground ambulance includes attendant services, drugs, supplies and cardiac monitoring.

Air/Water Ambulance

Medically appropriate air and water ambulance services are covered up to the maximum amount listed.

Air ambulance service involves transportation by means of a helicopter or fixed wing aircraft. The aircraft must be a certified ambulance and the crew, maintenance support crew and aircraft must meet the certification requirements and hold a certificate for air ambulance operators under Part 135 of the Federal Aviation Administration (FAA) regulations.

Water ambulance involves transportation by means of a boat. The boat must be specially designed and equipped for transporting the sick or injured and it must also have such other safety and lifesaving equipment as is required by state or local authorities.

Use of an air/water ambulance is medically necessary when the time needed to transport a patient by land, or the instability of transportation by land, poses a threat to the patient's condition or survival or the proper equipment required to treat the patient is not available on a land ambulance.

The patient must be transported for treatment to the nearest appropriate facility that is capable of providing a level of care for the patient's illness and that has available the type of Physician needed to treat the patient's condition.

This plan will only cover air and water ambulance services originating and terminating in the United States and its territories. Our allowance for the air/water ambulance includes attendant services, drugs, supplies and cardiac monitoring.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you should notify Personal Health Support as soon as possible prior to the transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

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

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

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

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

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:

certain Category B devices;
certain promising interventions for patients with terminal illnesses; and
other items and services that meet specified criteria in accordance with our medical and drug policies;

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

National Institutes of Health (NIH). (Includes *National Cancer Institute (NCI)*);
Centers for Disease Control and Prevention (CDC);
Agency for Healthcare Research and Quality (AHRQ);
Centers for Medicare and Medicaid Services (CMS);
a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or

The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

- ♦ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
- ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial;
- the patients receiving the investigational treatment must meet all protocol treatment;
- the facility and personnel providing the treatment must be capable of providing the treatment by virtue of their experience, training and volume of patients treated to maintain expertise;
- there must be no clearly superior non-investigational approach;
- the available clinical or preclinical data must provide a reasonable expectation that the treatment will be at least as worthwhile as the non-investigational alternative; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Benefits are not provided for that part of a Phase II clinical trial that is ordinarily paid for by one of the following:

- a national agency such as the National Cancer Institute, U.S. Department of Veteran Affairs or the Department of Defense.
- commercial organizations such as biotechnical, pharmaceutical or the medical device industry, either with or without the state.
- any other governmental or non-governmental source that customarily pays for all or part of a Phase II clinical trial.

Please remember that you should notify Personal Health Support as soon as the possibility of participation in a clinical trial arises.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about these guidelines.

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

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

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

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

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

Please remember for Non-Network Benefits, you should notify United Resource Networks or Personal Health SupportPersonal Health Support as soon as the possibility of a congenital heart disease (CHD) surgery arises.

Dental Services - Accident Only

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

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

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

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

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

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

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when medically appropriate.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including: ■ Therapeutic/molded shoes for the prevention of amputation. Limited to two pair of shoes or four individual shoes per calendar year. Includes inserts up to two pairs of inserts per pair of shoes or two inserts if only one shoe is dispensed. Additional inserts for depth shoes are covered up to three pairs of inserts per pair of shoes or three inserts if only one shoe is dispensed. Diabetic shoes and inserts must be purchased from a Durable Medical Equipment provider or a Physician to be a covered benefit; ■ blood glucose monitors, including blood glucose monitors for the legally blind; ■ insulin syringes with needles; ■ blood glucose and urine test strips; ■ ketone test strips and tablets; ■ lancets and lancet devices;

Covered Diabetes Services	
	■ test strips for visual reading; ■ cartridges for use by the legally blind; ■ injection aids; ■ oral agents for controlling blood sugar; ■ supplies and equipment approved by the FDA for the purposes for which they have been prescribed. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section.

Please remember for Non-Network Benefits, you should notify Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies.

Durable Medical Equipment (DME)

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

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

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

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;

- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part , braces to treat curvature of the spine, cranial banding, cranial orthoses or helmet and Hi-Knee-Ankle-Foot Orthosis (HKAFO) are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage, except as described under *Orthotic Devices* in this section. Dental braces are also excluded from coverage;
- orthopedic braces (except corrective shoes and orthotic devices used in connection with footwear);
- cranial bands;
- contact lenses or glasses following cataract surgery;
- therapeutic/molded shoes for the prevention of amputation for Covered Persons with diabetes. Limited to two pair of shoes or four individual shoes per calendar year. Includes inserts up to two pairs of inserts per pair of shoes or two inserts if only one shoe is dispensed. Additional inserts for depth shoes are covered up to three pairs of inserts per pair of shoes or three inserts if only one shoe is dispensed. Diabetic shoes and inserts must be purchased from a Durable Medical Equipment provider or a Physician to be a covered benefit; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

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

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc.,

for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Repairs and supplies to rental equipment are an expense of the vendor; repairs and supplies to equipment the Covered Person owns are the Covered Person's liability.

In accordance with Rhode Island Law, therapeutic/molded shoes for the prevention of amputation are covered for the treatment of diabetes (two pair of shoes or four individual shoes) is covered per calendar year, subject to medical appropriateness. Our allowances for molded shoes include the initial inserts. Additional inserts for custom-molded shoes are covered up to two pairs of inserts per pair of shoes or two inserts if only one shoe is dispensed. Additional inserts for depth shoes are covered up to three pairs of inserts per pair of shoes or three inserts if only one shoe is dispensed. Diabetic shoes and inserts must be purchased from a Durable Medical Equipment provider or a physician to be a covered benefit.

Please remember for Non-Network Benefits, you should notify Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing network physician.

Early Intervention Services

Preventive and primary services for a Dependent child younger than three years of age who is certified by the Rhode Island Department of Human Services as eligible for early intervention services. Covered Health Services include, but are not limited to, the following:

- Occupational therapy.
- Speech therapy.
- Physical therapy.
- Nursing care.
- Nutritional services.
- Psychological counseling.
- Assistive technology services and devices consistent with early intervention programs approved by the Department of Health.

Early intervention services must be provided by a licensed provider designated by the Department of Human Services as an "early intervention provider" and who works in early intervention programs approved by the Department of Health.

Emergency Health Services - Outpatient

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

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

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

Please remember for Non-Network Benefits, you should notify the Claims Administrator within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Enteral Nutrition Products

Nonprescription enteral formulas for home use as medically appropriate and ordered in writing by a Physician for the treatment of malabsorption caused by:

- Crohn's disease.
- ulcerative colitis.
- gastoresophageal reflux.
- chronic intestinal pseudo-obstruction
- inherited diseases of amino acids and organic acids including food products modified to be low protein.

Hearing Aids

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Benefits are not provided for batteries, cords, and other assistive listening devices such as FM systems.

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

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $5,000 in Eligible Expenses per calendar year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years. Please reference Section 5, *Plan Highlights* for cost share information.

Home Health Care

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

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Benefits are available for the following services:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Respiratory services.
- Medical social work.
- Nutritional counseling services.
- Prescription drugs and medications.
- Medical and surgical supplies.
- Minor equipment such as commodes and walkers.
- Laboratory and X-ray services, EEG and EKG evaluations.
- Home infusion therapies.

The following services are covered:

- Nursing visits billed by the agency;
- Total enteral nutrition Coverage does not include non-enteral formulas such as regular Infamil, regular Similac, soy milk products, and laxtose free products etc.;
- hydration therapy; antibiotic therapy;

- enteral nutrition;
- human growth hormone;
- pentamidine;
- immunoglobulin;
- chelation;
- drugs relating directly to the home infusion therapy;
- solutions;
- related equipment;
- supplies; and
- the services of the home infusion nurse.

Note: This plan does NOT cover radiation treatment services received in your home. This plan covers professionally administered injectable anti-neoplastic prescription drugs when they have been approved by us and are used solely for the purpose of cancer treatment.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before receiving services or as soon as reasonably possible. is not notified

Hospice Care

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

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before receiving services. is not notified

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

For Benefits related to mastectomy, we will pay Benefits for an Inpatient Stay of at least:

- 48 hours following a mastectomy.
- 24 hours following an axillary node dissection.

If the patient agrees, the attending provider may discharge the patient earlier than these minimum time frames, in which case Benefits will include a minimum of one home visit conducted by a Physician or registered nurse.

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

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

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

Please remember for Non-Network Benefits, you should notify Personal Health Support as follows:
- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

Infertility Services

The Plan pays Benefits for the treatment of infertility for:

- ovulation induction;
- insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI));
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); and
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office or in a Covered Person's home.

The Plan covers oral and injectable infertility drugs not obtained at the pharmacy. The Plan also covers donor gametes if provided through an approved program.

To be eligible for Benefits, the Covered Person must:

- be married;
- have failed to achieve a Pregnancy after a year of regular, unprotected intercourse; and
- have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

Please remember for Non-Network Benefits you should notify Personal Health Support as soon as the possibility of the need for infertility services arises.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

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

You or a covered Dependent may:

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

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

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

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

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- lab and radiology/x-ray;
- audiometric hearing tests; and
- mammography.

Benefits under this section include:

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

For Non-Network Benefits for sleep studies, you should notify Personal Health Support five business days before scheduled services are received.

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

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

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

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

Lyme Disease Treatment

Patient care services provided for the treatment of chronic Lyme disease to the same extent as Benefits would be provided for the treatment of other conditions, including evaluation,

diagnostic testing, and long-term antibiotic treatment when ordered by a Physician who has made a thorough evaluation of the patient's symptoms, diagnostic test results, and response to treatment. Patient care services provided for the treatment of chronic Lyme disease will not be denied solely because such services may be characterized as Unproven, Experimental or Investigational in nature if Benefits are generally provided for such services for the treatment of conditions other than chronic Lyme disease.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, community residence or Alternate Facility, in a provider's office or in a Covered Person's home.

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

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

The Plan provides parity in the Benefits for Mental Health/Substance Use Disorder services. This means that coverage of Benefits for Mental Health and Substance Use Disorders is comparable to, and not more restrictive than, the Benefits for physical health.

Financial requirements (such as Deductibles) or quantitative treatment limits (such as visit limits) that apply to Mental Health/Substance Use Disorder services within a category (such as Inpatient services) are not more restrictive than the Benefit limit that applies to the medical Benefits within that same category.

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

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

Special Mental Health Programs - Day Care:

This Plan covers the following psychiatric day care services for eight hours a day in an approved psychiatric day care program. It must be medically appropriate that you receive

supervised care through that program two or more times per week for a continuous eight hour period each time:

- Appropriate Hospital services;
- Professional and other staff services performed by employees of the facility under the supervision of a staff psychiatrist;
- A maximum of four (4) family therapy sessions for members of your family with mental health professionals employed by the facility;
- Intensive Outpatient Program: Individual and group therapy with medication management for a minimum of three (3) hours per day, normally three (3) days per week. This program provides substantial clinical support for patients who are either in transition from the Hospital to any outpatient setting or at risk for admission to inpatient care or other higher levels of care;
- CFIT – Child and Family Intensive Treatment Program - Services include up to seven (7) visits per week, consisting of ongoing emergency/crisis evaluations, out of home respite, psychiatric assessment, medication evaluation, case management, nursing services, and outpatient therapy;
- Mental Health Home Care- Individual or family therapy and/or medication management provided in the patient's home.

Electro-convulsive Therapy:

This Plan covers electro-convulsive therapy services when performed and billed by a Physician.

This Plan does NOT cover Physician visits and outpatient mental health visits on the same day that electro-convulsive therapy was performed. Anesthesia administered to you for electro-convulsive therapy is covered provided it is not administered by the same Physician who is performing the electro-convulsive therapy.

Please remember for Non-Network Benefits, you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment.notification. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card.

Newborn Care

Non-wellness services for a newborn child whose length of stay in the hospital exceeds the mother's length of stay.

Services are covered for the Dependent but are excluded for the newborn grandchild.

Neurobiological Disorders - Autism Spectrum Disorders Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating behaviors that are posing danger to self, others and that hinder everyday function.

An individual providing Applied Behavioral Analysis (ABA) services must be:

- individually licensed by the State of Rhode Island Department of Health as a healthcare provider/clinician and nationally certified as a Board Certified Behavior Analyst (BCBA); or
- individually nationally certified as a Board Certified Assistant Behavior Analyst (BCaBA) supervised by a Board Certified Behavior Analyst who is licensed by the State of Rhode Island Department of Health as a psychologist, social worker or therapist.
- for Network Benefits, the individual providing ABA services must also be a Network provider.

These Benefits describe only the psychiatric treatment for Autism Spectrum Disorders. Physical, occupational and speech therapy for the treatment of Autism Spectrum Disorders is a Covered Health Service; for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

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

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

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention; that are habilitative in nature; and that are backed by credible research; demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for; intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as ABA).

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

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

Please remember for Non-Network Benefits, you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment.notification. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card.

Nutritional Counseling

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

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

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

- diabetes mellitis;
- morbid obesity;
- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy);
- hyperlipidemia (excess of fatty substances in the blood);
- celiac disease;
- irritable bowel syndrome;
- obesity;
- family history of ischemic heart disease;
- family history of other cardiovascular disease.

Benefits are limited to six individual sessions per calendar year for each medical condition. This limit applies to non-preventive nutritional counseling services only.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

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

Please remember for Non-Network Benefits, you should notify Personal Health Support as soon as the possibility of obesity surgery arises.

Orthognathic Surgery

The Plan covers Orthognathic surgery for the following situations:

- a jaw deformity resulting from facial trauma or cancer; or
- skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:

inability to incise solid foods;
choking on incompletely masticated solid foods;
damage to soft tissue during mastication;
speech impediment determined to be due to the jaw deformity; or
malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Orthognathic surgery is not a Covered Health Service because it is considered unproven treatment due to a lack of evidence of improved functional clinical outcomes in peer reviewed, published medical literature, for the following symptoms:

- Myofascial, neck head and shoulder pain; or
- irritation of head/neck muscles

Treatment of malocclusion is dental and therefore not a covered health service.

Orthotic Devices

Orthotic Devices that support, correct or alleviate neuromuscular or musculoskeletal dysfunction, disease, injury or deformity, limited to custom fabricated, medically appropriate braces or supports that are:

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

If more than one orthotic device can meet your functional needs, Benefits are available only for the Orthotic Device that meets the minimum specifications for your needs. If you rent or purchase an Orthotic Device that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

The Plan will decide if the Orthotic Device should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- benefits are not available to replace lost or stolen items.

Please remember for Non-Network Benefits, you should notify Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing network physician.notified

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- surgical dressings;
- irrigation sleeves/trays, bags and ostomy irrigation catheters, colostomy/ileostomy supplies; and
- skin barriers.

Pharmaceutical Products - Outpatient

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

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

under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Benefits under this section do not include medications for the treatment of infertility.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

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

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

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

Please remember for Non-Network Benefits you should notify Personal Health Support for Genetic Testing – BRCA.

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

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications, newborn screening tests for metabolic, endocrine and hemoglobinopathy disorders.

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

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

No prior authorization is required for Inpatient Stays of these lengths. The Plan may not set the level of Benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-

hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

If the delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery. If the delivery occurs outside the hospital, the hospital length of stay begins at the time of admission.

There is no requirement that the mother stay in the hospital for a fixed period of time following the birth of her child. If the mother agrees, the attending provider may discharge her and/or the newborn child earlier.

There is no requirement that the mother give birth in a hospital.

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

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

The Plan covers one lactation support outpatient visit or home visit when ordered by the Physician. The appointment must occur within seven days after hospital discharge.

Please remember for Non-Network Benefits, you should notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from an approved breast pump provider or Network Physician. For a list of approved breast pump providers, please refer to www.myuhc.com or contact *Customer Care* at the telephone number shown on your ID card.

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

Prosthetic Devices

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

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

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

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

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or

when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.

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

For Non-Network Benefits you should notify Personal Health Support before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures

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

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery

(or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

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

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

- physical therapy;
- occupational therapy;
- Neuro-Rehabilitation Day Treatment;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

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

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Habilitative Services

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

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial

Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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

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

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

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

Benefits are limited to:

- 12 visits per calendar year for Manipulative Treatment (no additional visits allowed). Benefits include diagnosis and related services and are limited to one visit and treatment per day.
- 14 days before admittance to the Hospital or up to six weeks after discharge per calendar year for pulmonary rehabilitation therapy; and
- 3 visits per week up to 12 weeks per calendar year for cardiac rehabilitation therapy.

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

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before receiving Manipulative Treatment or as soon as reasonably possible.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;

- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

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

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*. The Plan does not cover health care services performed by a Physician, Surgeon or other person who is not legally qualified or licensed according to relevant sections of Rhode Island General Law, or other governing bodies or who does not meet our credentialing requirements.

Please remember for Non-Network Benefits, you should notify Personal Health Support as follows:
- for elective admissions: five business days before admission;
- for Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

Substance Use Disorder Services

Substance Use Disorder Services(also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, in a provider's office or in a Covered Person's home.

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

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

- Methadone maintenance services for medication assisted therapy for Substance Use Disorders, opioid overdoses, and chronic addiction within an appropriate classification based on the site of the service.

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

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

Please remember for Non-Network Benefits, you should notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card.

Surgery - Outpatient

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

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

For Non-Network Benefits for sleep apnea surgeries and orthognathic surgeries you should notify Personal Health Support five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

Temporomandibular Joint (TMJ) Services

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

Benefits are provided for surgical treatment if:

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

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

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

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before temporomandibular joint services are performed during an Inpatient Hospital Stay in a Hospital.

Therapeutic Treatments - Outpatient

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

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

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

Benefits under this section include:

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

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

Please remember for Non-Network Benefits, you should notify Personal Health Support for all outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible.

Tobacco Cessation Treatment - Outpatient

Tobacco Cessation counseling sessions received on an outpatient basis in a qualified provider's office or facility, or received from a qualified provider via a telephone counseling program.

Benefits are restricted to evidence based Tobacco Cessation Treatment counseling identified as effective in the most recent clinical practice guideline published by the *United States Department of Health and Human Services* entitled *Treating Tobacco Use and Dependence, A Clinical Practice Guideline.*

Transplantation Services

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

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

Benefits are available for one human leukocyte antigen testing per lifetime or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability, including testing for A, B, or DR antigens, or any combination of those tests.

Covered Hospital Services for transplants include: obtaining donated organs (including removal from a cadaver), donor medical and surgical expenses related to obtaining the organ, and transportation of the organ from donor to recipient.

The transplant benefit period begins five days before a covered organ transplant and continues through one year afterwards. During a benefit period, this plan covers the following services:

- covered Hospital expenses;
- the Physician's fee you are charged for surgical, medical and other services related to a covered organ transplant when these services are performed, ordered or supervised by a Physician.
- additional transplant charges for medically appropriate services and supplies during a transplant benefit period if they are not covered under this plan. They must be performed, ordered and/or supervised by a Physician.

Benefits are also available for cornea transplants. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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

Non-Network Benefits are limited to $30,000 per transplant.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Please remember for Non-Network Benefits, you should notify United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to transplantation services

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

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

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;

- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility for transplantation. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of $5,000 per Covered Person per transplant applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Treatment of Gender Dysphoria (Gender Identity Disorder)

The Plan pays Benefits for the treatment of gender dysphoria (Gender Identity Disorder) as described under non-surgical or surgical treatment for gender dysphoria.

Non-Surgical Treatment of Gender Dysphoria:

The Plan covers the following non-surgical treatments for gender dysphoria:

- Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in Section 6, *Additional Coverage Details*.
- Continuous hormone replacement therapy- hormones of the desired gender injected by a medical provider.

  Note. Coverage may be available for oral and self-injected hormones under the prescription drug products portion of the Plan.
- Laboratory testing to monitor the safety of continuous hormone therapy.

Surgical Treatment of Gender Dysphoria:

The Plan covers the following surgical treatment for gender dysphoria when the eligibility qualifications for surgery described below are met:

- Genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) and related services.

The treatment plan must conform to identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance; and
For irreversible surgical interventions, the Covered Person must be age 18 years or older, and
Prior to surgery, the Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender.

Important:

Certain Covered Person's will be required to complete continuous hormone therapy prior to surgery. In consultation with the Covered Person's Physician, this will be determined on a case-by-case basis.
Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

UnitedHealthcare has specific guidelines regarding Benefits for Treatment of Gender Dysphoria (Gender Identity Disorder). Contact UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only resulting from hair loss suffered due to treatment for any form of cancer or leukemia. A wig must be purchased from a Durable Medical Equipment Provider. A wig must also be prescribed by a Physician.

Any combination of Network Benefits and Non-Network Benefits is limited to $350 per calendar year.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Healthy Pregnancy.

State of Rhode Island believes in giving you the tools you need to be an educated health care consumer. To that end, State of Rhode Island has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

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

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

Consumer Solutions and Self-Service Tools

Health Improvement Plan

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

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and

- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders - State of Rhode Island's way of helping you meet your health and wellness goals.

NurseLine℠

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

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

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

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

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

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

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

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

Reminder Programs

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

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

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

Treatment Decision Support

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

This program offers:

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

Conditions for which this program is available include:

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

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

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the *UnitedHealth Premium®* program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the *UnitedHealth Premium® Program* including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

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

With **www.myuhc.com** you can:

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

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

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

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and

- order a new or replacement ID card or print a temporary ID card.

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

Disease and Condition Management Services

Disease Management Services

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

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

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

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

Diabetes Prevention

UnitedHealthcare provides a program that identifies, assesses, and supports members over the age of 18 living with pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior

modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPP call center directly at (888) 688-4019.

HealtheNotes℠

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

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

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

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

Healthy Pregnancy Program

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

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

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

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

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

What this section includes:

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

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

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

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

Alternative Treatments

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

Dental

1. dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

extractions (including wisdom teeth);
restoration and replacement of teeth;
medical or surgical treatments of dental conditions; and
services to improve dental clinical outcomes;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

7. treatment of malocclusion.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* or *Orthotic Devices* in Section 6, *Additional Coverage Details*. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter.

3. the following items are excluded, even if prescribed by a Physician:

blood pressure cuff/monitor;
enuresis alarm;
non-wearable external defibrillator;
trusses;
ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech including speech generating devices and tracheo-esophageal voice devices;

7. oral appliances for snoring.

Drugs

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

2. self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office;

5. over the counter drugs and treatments;

6. new Pharmaceutical Products and/or new dosage forms until the date they are reviewed;

7. a Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;

8. a Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year; and

9. benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

Experimental or Investigational or Unproven Services

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

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

cutting or removal of corns and calluses;
nail trimming or cutting; and
debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

cleaning and soaking the feet;
applying skin creams in order to maintain skin tone; and
other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics, unless it is a therapeutic/molded shoe for the prevention of amputation .

Medical Supplies and Equipment

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

over-the-counter compression stockings; stockings for prosthetics, elastic stockings, ace bandages, gauze and dressings and alcohol swabs.

This exclusion does not apply to:

ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; or
diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

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

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual* published by the *American Psychiatric Association* or the *International Classification of Disease Manual ("ICO")* published by the *World Health Organization*;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

not consistent with generally accepted standards of medical practice for the treatment of such conditions;
not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorders or condition based on generally accepted standards of medical practice and benchmarks.

3. Mental Health Services as treatments for R T, and Z-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, sexual dysfunctions, feeding disorders, communication disorders, motor disorders, binge-eating disorders, neurological disorders and other disorders with a known physical basis;

5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*

12. gambling disorders;

13. substance-induced sexual dysfunction disorders and substance-induced sleep disorders; and

14. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods);

2. food of any kind. Foods that are not covered include:

enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded except as described under *Enteral Nutrition Products* in Section 6, *Additional Coverage Details*;
foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
oral vitamins and minerals;
meals you can order from a menu, for an additional charge, during an Inpatient Stay; and other dietary and electrolyte supplements; and

3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. replacement batteries for blood glucose monitors;

6. supplies, equipment and similar incidentals for personal comfort. Examples include:

air conditioners;
air purifiers and filters;
batteries and battery chargers;
dehumidifiers and humidifiers;
ergonomically correct chairs;
non-Hospital beds, comfort beds, motorized beds and mattresses;
breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
car seats;
chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
electric scooters;
exercise equipment and treadmills;

hot tubs, Jacuzzis, saunas and whirlpools;
medical alert systems;
music devices;
personal computers;
pillows;
power-operated vehicles;
radios;
stair lifts or stair glides;
strollers;
safety equipment;
vehicle modifications such as van lifts;
video players; and
home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair lifts/glides).

7. Air/water ambulance for transport:

to a facility that is not an acute care Hospital, such as Physician's office, nursing facility, or the patient's home.
coverage for transport from cruise ships when not in United States waters.
transport from a facility that is not a hospital, such as a Skilled Nursing Facility, to another facility (such as a Hospital for non-emergent services or a Kidney Dialysis Center).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
pharmacological regimens;
nutritional procedures or treatments;
tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
hair removal or replacement by any means;
treatments for skin wrinkles or any treatment to improve the appearance of the skin;
treatment for spider veins;
skin abrasion procedures performed as a treatment for acne;
treatments for hair loss;
varicose vein treatment of the lower extremities, when it is considered cosmetic; and
replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and

4. wigs regardless of the reason for the hair loss except for scalp hair prosthesis for hair loss suffered due to treatment for any form of cancer or leukemia, in which case the Plan pays up to a maximum of $350 per Covered Person per calendar year.

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. chelation therapy, except to treat heavy metal poisoning;

10. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

11. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

12. the following treatments for obesity:

non-surgical treatment, even if for morbid obesity; and
surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

13. medical treatment of hyperhidrosis (excessive sweating). Only surgical and injection codes are covered for the treatment of hyperhidrosis;

14. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations, non-surgical treatment; and

15. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

prior to ordering the service; or
after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility;

2. surrogate parenting, donor eggs, donor sperm and host uterus;

3. the reversal of voluntary sterilization;

4. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

5. elective surgical, non-surgical or drug induced Pregnancy termination;

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

6. services provided by a doula (labor aide);

7. parenting, pre-natal or birthing classes;

8. genetic counseling and amniocenteses or any other service used to determine the sex of an infant before it is born; and

9. an induced abortion except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy resulted from rape or incest.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Treatment of Gender Dysphoria (Gender Identity Disorder)

1. reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
2. sperm preservation in advance of hormone treatment or gender surgery.
3. cryopreservation of fertilized embryos.
4. voice modification surgery.
5. facial feminization surgery, including but not limited to: facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.
6. treatment received outside of the United States.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 14, *Glossary;*
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Routine vision examinations, including refractive examinations to determine the need for vision correction, unless part of Preventive care services;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses (refer to *Durable Medical Equipment* in Section 6, *Additional Coverage Details* for coverage after cataract surgery);

4. bone anchored hearing aids except when either of the following applies:

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

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions;

5. eye exercise or vision therapy; and

6. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

missed appointments;
room or facility reservations;
completion of claim forms; or
record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

delivered in other than a Physician's office or health care facility; and
self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
that exceed Eligible Expenses or any specified limitation in this SPD;
for which a non-Network provider waives the Annual Deductible or Coinsurance amounts;

6. foreign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
related to judicial or administrative proceedings or orders; or
required to obtain or maintain a license of any type;

9. telephonic office visits, except as identified under *Tobacco Cessation Treatment – Outpatient* in Section 6, Additional Coverage Details.

SECTION 9 - CLAIMS PROCEDURES

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

Network Benefits

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

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

Non-Network Benefits

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

There are no claim forms to fill out other than the bill from the provider, but your request for payment must contain all of the required information as described below.

If Your Provider Does Not File Your Claim

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

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:

The Current Procedural Terminology (CPT) codes.
A description of, and the charge for, each service.
The date the Sickness or Injury began.
A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

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

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

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

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Health Statements

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

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

Explanation of Benefits (EOB)

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

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

What to Do if You Have a Question

Contact United Healthcare at the telephone number shown on your ID card. United Healthcare representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact United Healthcare at the telephone number shown on your ID card. United Healthcare representatives are available to take your call during regular business hours, Monday through Friday. If you would rather send your complaint to United Healthcare in writing, the United Healthcare representative can provide you with the appropriate address. If the United Healthcare representative cannot resolve the issue to your satisfaction over the telephone, he/she can help you prepare and submit a written complaint. United Healthcare will notify you of our decision regarding your complaint within 60 days of receiving it.

Rhode Island Consumer Assistance Program

Rhode Island's Office of the Health Insurance Commissioner provides assistance with questions, complaints and concerns through its consumer resource program RIREACH (Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline). RIREACH provides direct assistance to consumers who need help understanding and accessing their health coverage and is available to assist you at 1-855-747-3224 or www.RIREACH.org.

Adverse Benefit Determinations

An adverse benefit determination is a decision made by United HealthCare, in accordance with the terms of the Plan, to deny, reduce, terminate, or not pay for (in whole or in part) a benefit. Adverse benefit determinations include those based on your or your Dependent's eligibility for coverage (for example, a rescission of coverage) as well those based on Utilization Review.

Utilization Review means the review of the medical necessity and/or appropriateness of a health care service. This includes those services determined to be Experimental or Investigational and decisions not to authorize medications either on or outside of our Prescription Drug List ("PDL").

How to Appeal an Adverse Benefit Determination

Your appeal of an adverse benefit determination will fall under one of the following categories:

Post-service Claims

Post-service claims are claims that are filed for payment of Benefits after medical care has been received.

Post-service Requests for Benefits

Post-service requests for Benefits are requests for Benefits made after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests made for prior authorization or benefit confirmation prior to receiving medical care.

Concurrent Requests for Benefits

Concurrent requests for Benefits are requests made for authorization during the time while medical care is currently being received.

How to Request an Appeal

If you disagree with an adverse benefit determination made on a post-service claim, post-service request, pre-service request or concurrent request, you, your authorized representative, or your provider, can request an appeal in writing to formally request an appeal.

Your request for an appeal should include:

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

Your first appeal must be submitted to United Healthcare within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. Information about this process will be included in the final determination letter sent from United Healthcare.

You may also follow this process to appeal an adverse benefit determination based on rescission of coverage.

For procedures associated with urgent requests for Benefits, see Expedited Review of Urgent Appeals below.

Appeal Process

A qualified individual who was not involved in the initial decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. United Healthcare may consult, or seek the

participation of, medical experts as part of the appeal resolution process. You consent to this referral and to the sharing of pertinent medical claim information. United Healthcare will not make an adverse benefit determination until an appropriately qualified licensed practitioner has spoken with, or attempted to speak with, your attending or ordering physician. United Healthcare will make no less than the minimum number of documented attempts required by state law to reach your attending physician before reaching a determination.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim or request for Benefits, including copies of any internal rule, guideline or protocol that United Healthcare may rely on in reaching a determination. In addition, if any new or additional evidence is relied upon or generated by United Healthcare during the determination of the appeal, United Healthcare will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

If you are appealing an adverse benefit determination of a concurrent request for Benefits, coverage will be continued without financial liability beyond the applicable cost share until you are notified of the appeal determination.

Appeals Determinations

There are two levels of appeals for adverse benefit determinations. You will be provided written or electronic notification of the decision on your appeal as follows:

- Pre-service, concurrent, or post-service requests, or post-service claims – clinical matters:

  A first level appeal review will be conducted. You will be notified of the first level appeal decision within 15 days from receipt of a request with all the necessary information.

  If you are not satisfied with this decision, you can request a second level appeal. Your second level appeal request must be submitted to United Healthcare within 60 days from receipt of the first level appeal decision. You will be notified of the second level appeal decision within 15 days from receipt of a request with all the necessary information.

- Post-service claims - non-clinical matters

  A first level appeal review will be conducted. You will be notified of the first level appeal decision within 30 days from receipt of a request with all the necessary information.

  If you are not satisfied with this decision, you can request a second level appeal. Your second level appeal request must be submitted to United Healthcare within 60 days from your receipt of the first level appeal decision. You will be notified of the second level appeal within 15 days from receipt of a request with all the necessary information.

Please note that United Healthcare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure or service rendered. United Healthcare does not decide whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

You have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights,

and how to access those rights, will be provided in United Healthcare's decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call United Healthcare as soon as possible.
- United Healthcare will provide you with a written or electronic determination within 2 business days or 72 hours, whichever is earlier, following receipt of your request with all of the necessary information for review of the appeal, taking into account the seriousness of your condition.
- If United Healthcare need more information from your Physician to make a decision, United Healthcare will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review

After you complete the internal appeal process, if you remain dissatisfied with United Healthcare's final appeal determination, you may request an external review through an outside *Independent Review Organization* (*IRO*). United Healthcare will bear the cost of the external review although you may be responsible for a filing fee of up to $25 per claim, not to exceed $75 in a given plan year. There is no minimum dollar amount that a claim must be in order to file an external appeal.

The external appeal is voluntary. An external review is comprised of all of the following:

- a preliminary review by United Healthcare of the request.
- a referral of the request by United Healthcare to the *IRO*.
- a decision by the *IRO*.

To request an external review, you must submit your request in writing to United Healthcare along with your appeal fee within four (4) months of your receipt of United Healthcare's second level appeal review determination. A request for an external review of an urgent appeal may be made verbally. United Healthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has exhausted the applicable internal appeals process.

- has provided all the information and forms required so that United Healthcare may process the request.

After United Healthcare complete the preliminary review, if your request is eligible for external review, United Healthcare will forward your request and appeal fee to the *IRO* within five (5) business days for non-urgent appeals, or two (2) business days for an urgent appeal. United Healthcare will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

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

The *IRO* will notify you of its determination within ten (10) days for non-urgent appeals, or two (2) days for urgent appeals, after it receives this information. The determination of the *IRO* is binding upon United Healthcare.

You may contact United Healthcare at the toll-free number on your ID card for more information regarding external review rights.

Limitation of Action

You cannot bring any legal action against State of Rhode Island or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against State of Rhode Island or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against State of Rhode Island or the Claims Administrator.

You cannot bring any legal action against State of Rhode Island or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against State of Rhode Island or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against State of Rhode Island or the Claims Administrator. After an adverse benefit determination has been rendered, you cannot bring any legal action against us to recover reimbursement without first fully exhausting the internal and external appeals procedures provided in this section.

Any such failure to exhaust these administrative remedies prior to bringing suit may result in a judicial dismissal of your case.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

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

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

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

Determining Which Plan is Primary

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

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.

- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

The parents are married or living together whether or not they have ever been married and not legally separated.
A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

The parent with custody of the child; then
The Spouse of the parent with custody of the child; then
The parent not having custody of the child; then
The Spouse of the parent not having custody of the child.

- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

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

- The Plan determines the amount it would have paid based on the allowable expense.

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

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

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

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

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare,

the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

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

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

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

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

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

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

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amounts will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

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

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

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
Providing any relevant information requested by the Plan.
Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
Responding to requests for information about any accident or injuries;
Making court appearances.
Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

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

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

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

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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

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

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

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

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

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

When your coverage ends, State of Rhode Island will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- The date your employment with the Company ends which is the end of the biweekly pay period in which your date of termination occurs.
- The date the Plan ends.
- The date you stop making the required contributions.
- The date you are no longer eligible.
- The date UnitedHealthcare receives written notice from State of Rhode Island to end your coverage, or the date requested in the notice, if later.
- The date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

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

- The date your coverage ends.
- The date you stop making the required contributions.
- The date UnitedHealthcare receives written notice from State of Rhode Island to end your coverage, or the date requested in the notice, if later.
- The date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

Note: If UnitedHealthcare and State of Rhode Island find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact State of Rhode Island has the right to demand that you pay back all Benefits State of Rhode Island paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

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

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

The proof might include medical examinations at State of Rhode Island's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

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

Continuing Coverage Through COBRA

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

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if State of Rhode Island is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

- A Participant.

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

Qualifying Events for Continuation Coverage under COBRA

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

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
State of Rhode Island files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

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

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

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

How Your Medicare Eligibility Affects Dependent COBRA Coverage

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

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

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

Getting Started

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

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an

additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

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

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

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

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

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

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

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

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

Notification Requirements for Disability Determination

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information*. The contents of the notice must be such that the Plan Administrator is able to determine the

covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

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

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

When COBRA Ends

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

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

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

Uniformed Services Employment and Reemployment Rights Act

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

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

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

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

- The 24 month period beginning on the date of the Participant's absence from work.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

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

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

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and State of Rhode Island.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

Your Relationship with UnitedHealthcare and State of Rhode Island

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

- State of Rhode Island and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD).

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

State of Rhode Island and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. State of Rhode Island and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. State of Rhode Island and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between State of Rhode Island, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not State of Rhode Island's agents or employees, nor are they agents or employees of UnitedHealthcare. State of Rhode Island and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

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

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

State of Rhode Island is solely responsible for:

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

Your Relationship with Providers

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

- Are responsible for choosing your own provider.

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

Interpretation of Benefits

State of Rhode Island and UnitedHealthcare have the sole and exclusive discretion to:

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

State of Rhode Island and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

State of Rhode Island and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. State of Rhode Island and UnitedHealthcare may request additional information from you to decide your claim for Benefits. State of Rhode Island and UnitedHealthcare will keep this information confidential. State of Rhode Island and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish State of Rhode Island and UnitedHealthcare with all information or copies of records relating to the services provided to you. State of Rhode Island and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. State of Rhode Island and UnitedHealthcare agree that such information and records will be considered confidential.

State of Rhode Island and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms

of the Plan, for appropriate medical review or quality assessment, or as State of Rhode Island is required to do by law or regulation. During and after the term of the Plan, State of Rhode Island and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements State of Rhode Island recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, State of Rhode Island and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Workers' Compensation Not Affected

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

Future of the Plan

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

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

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

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

Plan Document

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

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

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

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

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

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

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

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

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

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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

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

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

BMI - see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by State of Rhode Island. The CRS program provides:

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

CHD - see Congenital Heart Disease (CHD).

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

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

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

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

Common Law Spouse - Your spouse by common law of the opposite gender is eligible to enroll for coverage under this plan if you and your Common Law Spouse complete and sign our Affidavit of Common Law Marriage and we receive the necessary proof, as determined by us.

Company - State of Rhode Island.

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

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

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

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

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, Plan Highlights and Section 6, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

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

is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

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

Designated Physician - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.

- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must reside together and have resided together for at least one year.
- They must be financially interdependent.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

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

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

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

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

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, which is both of the following:

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

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

Employer - State of Rhode Island.

EOB - see Explanation of Benefits (EOB).

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

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

Exceptions:

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

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

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.

- The reason(s) why the service or supply was not covered by the Plan.

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

Gender Identity Disorder – A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

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

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

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

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

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

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

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

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

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

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

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

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

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by State of Rhode Island. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

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

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

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by State of Rhode Island who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

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

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by State of Rhode Island, during which eligible Participants may enroll themselves and their Dependents under the Plan. State of Rhode Island determines the period of time that is the Open Enrollment period.

Orthotic Device - a custom fabricated brace or support that is designed based on medical appropriateness. The term Orthotic Device does not include prefabricated or direct-formed orthotics or assistive technology devices.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

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

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

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

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, licensed mid-wife, nurse, nurse anesthetist, nurse first assistant, certified registered nurse practitioner, marriage and family therapist, mental health counselor or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The State of Rhode Island Medical Plan.

Plan Administrator - State of Rhode Island or its designee.

Plan Sponsor - State of Rhode Island.

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

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

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

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

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

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

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:

Room and board.
Evaluation and diagnosis.
Counseling.
Referral and orientation to specialized community resources.

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

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

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

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

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

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

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

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

Spouse - an individual to whom you are legally married, a Common Law Spouse or a Domestic Partner as defined in this section.

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

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

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

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

To be designated as a UnitedHealth Premium® provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium® Program Physician or facility.

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

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

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

Please note:

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

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

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

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

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

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

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

Additional Plan Description

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

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

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

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

ATTACHMENT III– HEALTH SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts.
- Who is eligible and how to enroll.
- Contributions.
- Additional medical expense coverage available with your Health Savings Account.
- Using the HSA for Non-Qualified Expenses.
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the State of Rhode Island Medical Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

State of Rhode Island has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by State of Rhode Island. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- State of Rhode Island Medical Plan, a high deductible medical plan which is discussed in your Summary Plan Description.
- An HSA you establish.
- Health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

What is an HSA?
An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA).
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare).
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. State of Rhode Island and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. State of Rhode Island and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this

information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

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

> ***Important***:
> UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

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

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

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

> ***Important***:
> You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.