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SECTION 1 - INTRODUCTION

Quick Reference Box
- Member services, claim inquiries and Care CoordinationSM: (877) 442-6003;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555; and

Eligibility Requirements

Employee Eligibility

You are eligible for health care benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

This Plan does not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Married State Employees

When a husband and wife are both employed by the state, both employees cannot carry family coverage for medical, dental or vision. You have the following options:

- Both may carry single coverage
- Both may be covered by one family plan
- One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan

Examples of Employees NOT Eligible for Coverage

- Temporary
- Seasonal
- Intermittent
- Interim
- Student or college intern

Dependent Eligibility

Family members as described below may be eligible for coverage under your medical benefits. (Please go to: das.ohio.gov/eligibilityrequirements for the Definitions and Required Documents checklist for documentation required to enroll a dependent.)

1. Spouse. Your current legal spouse as recognized by Ohio law.
2. Unmarried Children under Age 19 including:

- Your biological children
- Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
- Your dependent stepchildren: stepchildren must live with you 50% or more of the time
- Foster children who normally reside with you
- Children for whom either you or your spouse has been appointed legal guardian and who normally reside with you
- Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the QMCSO

3. Unmarried Children Age 19 through 22 - Student Status

Your unmarried children age 19 or older, who are attending an accredited school full-time or part-time, are eligible until the end of the month in which they either reach age 23 or cease being a student - whichever occurs first.

Student coverage is not automatic. The State will annually request proof of school enrollment along with a completed Affidavit of Student Status (ADM 4729) form (available at: das.ohio.gov/eligibilityrequirements. When you provide this proof, your dependent will continue to be covered. If the requested proof is not provided to the State, their coverage ends on the last day of their birthday month.

Michelle’s Law prohibits health plans from terminating coverage for a dependent child who is a student at a postsecondary institution and who is on a medically necessary leave of absence from school that started July 1, 2010 or later.

To qualify for coverage under this federal provision, the dependent child must be enrolled in the plan, on the basis of student status, immediately prior to the first day of the leave. The leave must begin while the student is suffering from a serious illness or injury, be medically necessary and cause the dependent child to lose student status for purposes of coverage under the plan. Additionally, the student must present written certification from his or her physician indicating that he or she is suffering from a serious illness or injury that necessitates the leave.

Coverage under Michelle’s Law continues until either one year after the first day of the medically necessary leave or the day that the student’s coverage would have otherwise ended, whichever is earlier.

4. Unmarried Children Incapable of Self-Care

Unmarried children who are incapable of self-support due to mental retardation, severe mental illness, or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled.
for coverage, provided that the application is submitted within five (5) years following loss of coverage.

This coverage is not automatic. You must complete the applicable form for this plan. The form can be found at das.ohio.gov/healthplanforms.

The form must be completed and sent to this plan no later than 31 days prior to the dependent’s 19th birthday, or upon being diagnosed with a disabling condition between the ages of 19 and 23. Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

5. HB1 Child

Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. HBI coverage is available for medical (including pharmacy and mental health) coverage only.

HB1 Child requirements:

■ Your unmarried child, age 19 through 27, and who is not a student status child aged 19 through 22, as described above; and

■ Child is your natural child, stepchild or adopted child; and

■ Child is a resident of Ohio or a full time student at an accredited public or private institution of higher education; and

■ Child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and

■ Child is not eligible for state Medicaid or federal Medicare

A special rate applies for these children.

You can enroll your HB1 Child with the Annual Affidavit of House Bill 1 Child (available at: das.ohio.gov/eligibilityrequirements).

When you enroll your HB1 Child, you must indicate on the applicable form whether the child qualifies as an IRS tax dependent or a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year. You may wish to consult with an independent tax advisor as to your HB1 child's status under the Internal Revenue Code and IRS regulations. If your HB1 child qualifies as an IRS tax dependent or as a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year, the deduction for coverage will occur before adjusted gross income is calculated (pre-tax dollars). If your HB1 child does not meet one of these qualifications, the deduction for coverage will occur after adjusted gross income is calculated.

An employee may enroll or disenroll an HB1 Child during open enrollment, when the child reaches the plan’s limiting age, or when a child experiences a change in circumstances. Examples of a change in circumstance (Ohio Administrative Code 3901-8-13) include moving back to Ohio or the child’s loss of employer-sponsored coverage.
To enroll or disenroll an HB1 Child, the employee must notify the State’s DAS HCM Customer Service within 30 days of the change in circumstance. You may notify DAS HCM Customer Service by sending an email to dashrd.hcmOAKSsupport@das.state.oh.us or by calling 614.466.8857 or 1.800.409.1205. Upon receiving your request, your child will be offered the opportunity to enroll in HB1 coverage within thirty days. If eligible, coverage will be effective at the beginning of the plan year for open enrollment enrollees, and within 30 days of receiving notice of the election and the required documentation.

Examples of Persons NOT Eligible for Coverage as a Dependent:

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 28 or older
- A spouse or child currently in the military service, eligible for coverage under a federal health plan
- Married children
- Same-sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Adults who are not the employee’s or spouse’s child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- Common law spouse in which the relationship began in Ohio after October 10, 1991
- A child who is eligible for coverage as an employee of the state or who receives health care coverage through their own employment
- Stepchildren not living with the employee at least 50% of the time
- Any other members of your household who do not meet the definition of an eligible dependent

It is your responsibility to disenroll a family member who is no longer eligible for coverage.

Knowingly providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

Cost of Coverage

You and State of Ohio share in the cost of the Plan. Your contribution amount depends on your appointment type, the Plan you select, and the family members you choose to enroll.

Your contributions are subject to review and State of Ohio reserves the right to change your contribution amount from time to time.
You can obtain current contribution rates by calling your agency’s Human Resources office.

**How to Enroll**

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

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

**Important**

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

**When Coverage Begins**

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

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

**Changing Your Coverage**

Under normal circumstances, you cannot change or drop your health benefits coverage unless you experience a qualifying event. Any changes outside of open enrollment must be in compliance with the applicable rules of the Internal Revenue Code Section 125 which may include but not be limited to the following:

1. After marriage, death of a spouse, divorce, legal separation, or annulment, in which case coverage becomes effective the first day of the month following the month of the event.

2. Birth, adoption, placement for adoption, or death of a dependent, in which case coverage becomes effective with the birth, adoption, or placement of a child or date of death.
3. Termination or commencement of employment by the employee, spouse or dependent, in which case coverage becomes effective the first day of the month following the month of application.

4. Reduction or increase in hours of employment by the employee (including layoff or reinstatement from layoff), spouse, or dependent, including a switch between part-time and full-time, strike, lockout, or commencement, return to work from an unpaid absence, or change in work site in which case coverage becomes effective the first day of the month following the month of application.

5. Return to work through order of arbitration or settlement of a grievance, or any administrative body with authority to order the return to work of an employee.

6. The employee’s dependent satisfies or fails to satisfy the requirement of the definition of dependent due to attainment of age, student status or any similar circumstance as provided in the Health Plan under which the employee receives coverage.

7. If the plan receives a Qualified Medical Child Support Order (QMCSO) pertaining to an employee’s dependent, the employee may elect to add or drop the child to the plan depending upon the requirement of the QMCSO.

8. If an employee, spouse, or dependent who is enrolled in a health plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

9. If an employee, spouse, or dependent is no longer entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

Requests for changes pursuant to Sections (1) through (9) must be supported by proper documentation.

10. An employee may change health plans if the employee either no longer resides or no longer works in the service area of the employee’s current health plan.

Unless otherwise noted above, if you wish to change your elections, you must notify your agency’s Human Resources office within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.
SECTION 2 - HOW THE PLAN WORKS

What this section includes:
- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum;
- Lifetime Maximum Benefit; and
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for 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. Except as specifically described within the booklet benefits are not available for services provided by a non-Network provider.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

Network Providers

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

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

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.
**Possible Limitations on Provider Use**

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

**Health Services from Non-Network Providers Paid as Network Benefits**

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

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

**Eligible Expenses**

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 13, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. State of Ohio has delegated to UnitedHealthcare the initial 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.

**Don't Forget Your ID Card**

Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network 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 plan year for Covered Health Services Expenses before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the plan year.

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

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.
Copayment
A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

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

**Coinsurance - Example**
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider totaling $1000. Since the Plan pays 80% or $800, you are responsible for paying the other 20%, or $200. This 20% or $200, is your Coinsurance.

Out-of-Pocket Maximum
The annual Out-of-Pocket Maximum is the most you pay each plan year for Covered Health Services. If your eligible out-of-pocket expenses in a plan year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the plan year.

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

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<td>Yes</td>
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<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
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<td>Coinsurance Payments</td>
<td>Yes</td>
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<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
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</table>
**How the Plan Works - Example**

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums, Lifetime Maximum Benefits and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician.

<table>
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<th>Network Benefits</th>
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<tbody>
<tr>
<td>1. Gary goes to see a Network Physician, and presents his ID card.</td>
</tr>
<tr>
<td>2. He receives treatment from the Physician. The Eligible Expense for the Network office visit equals $125.</td>
</tr>
<tr>
<td>3. On his way out, Gary pays a $20 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.</td>
</tr>
<tr>
<td>4. The Plan pays $105 ($125 Eligible Expense minus $20 Copay).</td>
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SECTION 3 - CARE COORDINATION℠

What this section includes:
- An overview of the Care Coordination℠ program; and
- Covered Health Services for which you need to contact Care Coordination℠.

UnitedHealthcare provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ 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 Care Coordination℠ nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Care Coordination℠ program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Care Coordination℠ nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.

- **Inpatient care advocacy** - If you are hospitalized, a Care Coordination℠ 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 Care Coordination℠ nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care Coordination℠ 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 Care Coordination℠ 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 Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.
Requirements for Notifying Care Coordination℠

In most cases, Network providers are responsible for notifying Care Coordination℠ before they provide these services to you. However, you are responsible for notifying the Care Coordination℠ staff prior to receiving a service for:

- ambulance – non-emergent air and ground;
- dental services - accident only;
- obesity surgery; and
- transplantation services.

Contacting Care Coordination℠ is easy.
Simply call the toll-free number on your ID card (877) 442-6003.

Special Note Regarding Medicare

If you are enrolled in Medicare and Medicare pays benefits before the Plan, you are not required to notify Care Coordination℠ before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 9, Coordination of Benefits (COB).
### SECTION 4 - PLAN HIGHLIGHTS

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong>¹</td>
<td></td>
</tr>
<tr>
<td>■ Emergency Health Services</td>
<td>$75</td>
</tr>
<tr>
<td>■ Physician's Office Services</td>
<td>$20</td>
</tr>
<tr>
<td>■ Urgent Care Center Services</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong>²</td>
<td></td>
</tr>
<tr>
<td>■ Individual</td>
<td>$200</td>
</tr>
<tr>
<td>■ Family (not to exceed the individual Annual Deductible amount per Covered Person)</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong>³</td>
<td></td>
</tr>
<tr>
<td>■ Individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>■ Family (not to exceed the individual Annual Out-of-Pocket Maximum amount per Covered Person)</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong>³</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

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

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

³The Lifetime Maximum Benefit includes any other maximums per lifetime specific to Benefits identified in Section 5, *Additional Coverage Details.*
This table provides an overview of the Plan’s coverage levels. For detailed descriptions, including limitations and requirements, of your Benefits, refer to Section 5, *Additional Coverage Details*.

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Services</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>■ Emergency Ambulance</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Non-Emergency Ambulance</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Cancer Resource Services (CRS)</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>■ Hospital Inpatient Stay</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>■ Hospital Inpatient Stay</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>■ Hospital Inpatient Stay</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</td>
<td>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.</td>
</tr>
<tr>
<td>■ Diabetes Self-Management Items</td>
<td>Benefits for diabetes equipment will be the same as those stated under <em>Durable Medical Equipment</em> in this section except as follows-</td>
</tr>
<tr>
<td>■ diabetes equipment</td>
<td>100% and No Annual Deductible if enrolled in State of Ohio’s sponsored disease management program for:</td>
</tr>
<tr>
<td>■ external insulin pumps</td>
<td></td>
</tr>
<tr>
<td>■ internal insulin pumps</td>
<td></td>
</tr>
<tr>
<td>■ infusion sets</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Network</td>
<td>§ continuous blood glucose monitoring equipment sensor pads</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>80% after you meet the Annual Deductible and you pay a $75 Copay</td>
</tr>
<tr>
<td>Emergency services received at a non-Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving outpatient Emergency treatment for the same condition, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead. Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Care Coordination℠ 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.</td>
<td></td>
</tr>
<tr>
<td>Hearing Care (Copay is per visit)</td>
<td>80% after you meet the Annual Deductible and you pay a $20 Copay</td>
</tr>
<tr>
<td>Hearing aids:</td>
<td>80% after you meet the Annual Deductible for accident, injury or illness. No lifetime maximum.</td>
</tr>
<tr>
<td>50% after you meet the Annual Deductible strictly for the correction of hearing loss due to natural causes for one hearing aid per lifetime up to $1,000.</td>
<td></td>
</tr>
</tbody>
</table>
### Covered Health Services

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Up to 100 visits or 180 days, whichever is greater</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital - Inpatient Stay</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Kidney Resource Services (KRS)</strong></td>
<td>(These Benefits are for Covered Health Services provided through KRS only)</td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Diagnostics - Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Neonatal Resource Services (NRS)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>Limited to 2 visits per patient per condition per year except for obesity counseling which has no visit limit. All other conditions have the 2 visit per year limit.</td>
</tr>
<tr>
<td><strong>Obesity Surgery</strong></td>
<td>■ Physician's Office Services</td>
</tr>
<tr>
<td></td>
<td>■ Physician Fees for Surgical and Medical Services</td>
</tr>
<tr>
<td></td>
<td>■ Hospital - Inpatient Stay</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physician's Office Services - Sickness and Injury</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Health Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage of Eligible Expenses Payable by the Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy – Maternity Services</td>
<td>100%</td>
</tr>
<tr>
<td>■ Physician’s Office Services</td>
<td>80% after you meet the Annual Deductible and you pay a $20 Copay</td>
</tr>
<tr>
<td>Pre-natal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness and Injury</td>
<td></td>
</tr>
<tr>
<td>■ Hospital - Inpatient Stay</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Physician Fees for Surgical and Medical Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother’s length of stay.</td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
</tr>
<tr>
<td>■ Physician Office Services</td>
<td>100%</td>
</tr>
<tr>
<td>■ Lab, X-ray or Other Preventive Tests</td>
<td>100%</td>
</tr>
<tr>
<td>■ See Section 5: Preventive Care for Covered Services.</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td></td>
</tr>
<tr>
<td>■ Physician’s Office Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Hospital - Inpatient Stay</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Physician Fees for Surgical and Medical Services</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Prosthetic Devices</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Surgery - Outpatient</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment</strong>&lt;br&gt;(Copay is per visit)&lt;br&gt;Benefits for Chiropractic Treatment are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.&lt;br&gt;Benefits are limited to 20 visits per plan year for Chiropractic Treatment.&lt;br&gt;Benefits are limited to 30 visits per plan year for physical and occupational therapy combined.</td>
<td>80% after you meet the Annual Deductible and you pay a $20 Copay</td>
</tr>
<tr>
<td><strong>Scopic Procedures - Outpatient Diagnostic and Therapeutic</strong>&lt;br&gt;See Section 5: Preventive Care for Covered Services.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong>&lt;br&gt;180 day limit 80%, additional days covered at 60%</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Surgery - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Therapeutic Treatments - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Transplantation Services</strong>&lt;br&gt;(If services rendered by a Designated Facility)&lt;br&gt;Up to $1,000,000 per lifetime</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Travel and Lodging</strong>&lt;br&gt;(If services rendered by a Designated Facility)</td>
<td>For patient and companion(s) of patient undergoing transplant procedures</td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Urgent Care Center Services**  
(Copay is per visit) | **Network**  
80% after you meet the Annual Deductible and you pay a $25 Copay |

¹In general, your Network provider must notify Care Coordination℠, as described in Section 3, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for notifying Care Coordination℠. See Section 5, Additional Coverage Details for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under Physician’s Office Services - Sick and Injury, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic, Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.
SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

■ Covered Health Services for which the Plan pays Benefits; and
■ Covered Health Services that require you to notify Care Coordination\textsuperscript{SM} before you receive them, and any reduction in Benefits that may apply if you do not call Care Coordination\textsuperscript{SM}.

This section supplements the second table in Section 4, Plan Highlights.

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Care Coordination\textsuperscript{SM}. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, Exclusions.

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 13, 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, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

■ 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.

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 13, 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 Care Coordination℠ Nurse;
call CRS toll-free at (866) 936-6002; or
visit www.urncrs.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).

**Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. 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 Care Coordination℠ to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care Coordination℠ 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.

**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 damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- 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.)

The following services are also covered by the Plan:

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three 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 Care CoordinationSM 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, Care CoordinationSM can determine whether the service is a Covered Health Service.

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

<table>
<thead>
<tr>
<th>Covered Diabetes Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Self-Management</strong> and Training/ Diabetic Eye Examinations/Foot Care</td>
</tr>
</tbody>
</table>
| **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, but not limited to:  
■ blood glucose monitors.  
Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment in this section. |

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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

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;
■ burn garments;
■ insulin pumps and all related necessary supplies as described under Diabetes Services in this section;
■ braces that straighten or change the shape of a body part;
■ external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy and Surgery – Outpatient in this section;
■ braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.; and
■ equipment for the treatment of chronic or acute respiratory failure or conditions.

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

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see Prosthetic Devices in this section.
Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three plan 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 anytime and are not subject to the three year timeline for replacement.

**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.

If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for an Emergency Health Service, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Care Coordination℠ 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, no Benefits will be paid.

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

**Hearing Care**

Benefits are available for the following Covered Health Services when received from a provider in the provider's office:

- routine hearing exams;
- hearing exams in case of accident, injury or illness; and
- hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. 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.

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.

Hearing aids are covered at 80% after you meet the Annual Deductible for accident, injury or illness with no lifetime maximum and 50% after you meet the Annual Deductible strictly for the correction of hearing loss due to natural causes for one hearing aid per lifetime up to $1,000.

**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 13, **Glossary**; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Section 13, **Glossary** for the definition of Skilled Care.

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

Benefits are limited to the first 100 visits or 180 days, whichever is greater. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

**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 and spiritual 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.

**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 anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists.

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 Services, and Therapeutic Treatments - Outpatient, respectively.

**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 13, 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 Care Coordination<sup>SM</sup>, or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

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

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 include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

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

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

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.

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 anesthesiologists, pathologists and radiologists.

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

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Facilities participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Facility is defined in Section 13, Glossary.
In order to receive Benefits under this program, the Network provider must notify NRS or Care Coordination℠ if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- call Care Coordination℠; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, 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.

**Nutritional Counseling**

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

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

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to 2 visits per patient per condition per year except for obesity counseling which has no visit limit. All other conditions have the 2 visit per year limit.
**Obesity Surgery**

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following are 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;

In addition to meeting the above criteria the following must also be true:

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you are over the age of 21; and
- you have completed a 6-month physician supervised weight loss program.

The Plan covers surgical treatment of morbid obesity, provided the service or supply is certified in accordance with Clinical Review by the Claims Administrator.

**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.

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

**Physician's Office Services - Sickness and Injury**

Benefits are paid by the Plan for Covered Health Services received in a Primary 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 for preventive services are described under *Preventive Care* in this section. Benefits for preventive hearing care are described under *Hearing Care* in this section.

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

**Please Note**

Your Physician does not have a copy of your booklet, and is not responsible for knowing or communicating your Benefits.
Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

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

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

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

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

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, Resources to Help you Stay Healthy, for details.

Preventive Care Services

The Plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

In general, the Plan pays preventive care Benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.
Examples of Covered Health Services for preventive care include:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>$0 Co-Pay Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-baby, well-child exam</td>
<td>Various for birth to 2 years; then annual to age 18</td>
</tr>
<tr>
<td>Well-person exam (annual physical)</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Hemoglobin, hematocrit, or CBC</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Lipid profile or total and HDL cholesterol</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Glucose</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Stool for occult blood</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Pre-natal office visits</td>
<td>As needed; based on physician’s ability to code claims separately from other maternity-related services</td>
</tr>
<tr>
<td>GYN exam</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Clinical breast exam</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Pap</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Mammogram</td>
<td>1 base line between ages 35-39; 1 per Plan year for 40+</td>
</tr>
<tr>
<td>PSA</td>
<td>1 per Plan year starting at age 40</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>Every 10 years starting at age 50</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Every 10 years starting at age 50</td>
</tr>
</tbody>
</table>

**Immunizations**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>$0 Co-Pay Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>Birth; 1-2 mos; 6-18 mos</td>
</tr>
<tr>
<td>Rotavirus (Rota)</td>
<td>2/4/6 mos</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis (DTaP)</td>
<td>2/4/6/15-18 mos; 4-6 yr</td>
</tr>
<tr>
<td>Vaccine Type</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Tetanus, diptheria, pertussis (Td/Tdap)</td>
<td>11-12 yrs; Td booster every 10 yrs, 18 and older</td>
</tr>
<tr>
<td>Haemophilus influenzae b (Hib)</td>
<td>2/4/6/12-15 mos</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>2/4/6 mos; 12-15 mos; annually at age 65 and older; high risk groups</td>
</tr>
<tr>
<td>Poliovirus (IPV)</td>
<td>2 and 4 mos; 6-18 mos; 4-6 yrs</td>
</tr>
<tr>
<td>Influenza</td>
<td>1 per Plan year</td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>12-15 mos; then at 4-6 yrs; adults who lack immunity</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>12-15 mos; 4-6 yrs; 2 doses for adult susceptibles</td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>2 doses b/w 1-2 yrs</td>
</tr>
<tr>
<td>Meningococcal (MCV4)</td>
<td>1 dose between 11-12 years or start of high school or college</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>3 doses for females age 9 through age 26 years</td>
</tr>
<tr>
<td>Zoster (shingles)</td>
<td>1 dose for age 60+</td>
</tr>
</tbody>
</table>

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 noses; and
- speech aid prosthetics and tracheo-esophageal voice prosthetics; and
- breast prosthesis following mastectomy as required by the Women’s Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

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

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 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 plan 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.

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

**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 13, *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 Care Coordination SM five business days before undergoing a Reconstructive Procedure. When you provide notification, Care Coordination SM can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Chiropractic Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits are limited to:

- 20 visits per plan year for Chiropractic Treatment; and
- 30 visits per plan year for physical and occupational therapy combined.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

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

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

**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; and
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists.

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; and
- it is ordered by a Physician;
it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; 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 13, *Glossary.*

180 day limit 80%, additional days covered at 60%.

**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, hysteroscopy); 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 - Sickness and Injury* in this section.

**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 but not limited to 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.

**Transplantation Services**

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. 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 also available for cornea transplants. You are not required to notify United Resource Networks or Care CoordinationSM 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.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Care CoordinationSM at the telephone number on your ID card for information about these guidelines.
Benefits are limited to $1,000,000 per Covered Person during the entire period you are covered under the Plan.

**Travel and Lodging**

United Resource Networks 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. 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 maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures during the entire period that person is covered under this Plan.

**Support in the event of serious illness**

If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.
Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 13, *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.
SECTION 6 - RESOURCES TO HELP YOU STAY HEALTHY

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

■ [www.myuhc.com](http://www.myuhc.com); and
■ UnitedHealth Premium℠ Program on [www.myuhc.com](http://www.myuhc.com).

State of Ohio believes in giving you the tools you need to be an educated health care consumer. To that end, State of Ohio 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 Ohio 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.

[www.myuhc.com](http://www.myuhc.com)

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

**Health Information**

With [www.myuhc.com](http://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;
■ 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.
**Self-Service Tools**
Visit [www.myuhc.com](http://www.myuhc.com) and:

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

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

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

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

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

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

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

- help you make informed decisions on where to receive care;
provide you with decision support resources; and

give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.
SECTION 7 - 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 5, Additional Coverage Details.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 5, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 4, 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 4, 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 booklet 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 booklet 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 Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 5, Additional Coverage Details.
Dental

1. dental care, except as identified under Dental Services - Accident Only in Section 5, Additional Coverage Details;

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

   Endodontics, periodontal surgery and restorative treatment are excluded, except for osseous surgery. If no dental insurance exists or does not cover osseous surgery, such surgery shall be covered as any other surgery.

2. diagnosis or 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 5, Additional Coverage Details.

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 5, Additional Coverage Details.

4. dental braces (orthodontics);

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

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

Devices, Appliances and Prosthetics

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

2. orthotic appliances and devices, except when all of the following are met:
   - prescribed by a Physician for a medical purpose;
STATE OF OHIO MEDICAL CHOICE PLAN

- custom manufactured or custom fitted to an individual Covered Person; and
- diabetic footwear for a Covered Person with diabetic foot disease.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, cranial bands, or any braces that can be obtained without a Physician's order.

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 except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 5, Additional Coverage Details; and

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 except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 13, 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.
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 5, 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, except when needed as preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. 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;

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

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

7. shoe orthotics, except when needed as preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

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:

   - elastic stockings, compression hose, ace bandages, diabetic strips, and syringes;
   - ostomy bags and related supplies; and
   - urinary catheters.

   This exclusion does not apply to:

   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Diabetes Services in Section 5, Additional Coverage Details; or
   - diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 5, 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 clears, adhesive, or adhesive remover.

Nutrition
1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups except as identified under Diabetes Services, and except as defined under Nutritional Counseling in Section 5, Additional Coverage Details;

3. food of any kind. Foods that are not covered include:
   - 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;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

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

Personal Care, Comfort or Convenience
1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:
   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, 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;
- 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 glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 13, *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. 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 Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 5, Additional Coverage Details;
3. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

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

5. wigs regardless of the reason for the hair loss; and

6. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

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

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

4. 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 in Section 5, Additional Coverage Details;

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

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

7. psychosurgery (lobotomy);

8. treatment of tobacco dependency;

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

10. Chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, 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. sex transformation operations;

13. 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 5, Additional Coverage Details;

14. medical and surgical treatment of hyperhidrosis (excessive sweating);

15. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature, including oral appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

16. diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite), jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea; and

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or other diseases.

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. foreign language and sign language interpreters;

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

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

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

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

This exclusion does not apply to mammography testing.
Reproduction
1. health services and associated expenses for infertility treatments, including In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, artificial insemination and other assisted reproductive technology, regardless of the reason for the treatment.

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

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

3. 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;

   The Plan will not provide any benefits or services related to non-therapeutic abortions for any State of Ohio employee or Dependent. For the purposes of this contract, “non-therapeutic” is defined as an abortion that is performed or induced when the life of the mother would not be endangered if the fetus were carried to term, or when the pregnancy was not the result of rape or incest reported to a law enforcement agency.

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

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan
Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 9, Coordination of Benefits (COB);

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

3. while on active military duty; and

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

Transplants
1. health services for organ and tissue transplants except as identified under Transplantation Services in Section 5, Additional Coverage Details unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare’s transplant guidelines;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

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

**Travel**

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

**Types of Care**

1. Custodial Care as defined in Section 13, *Glossary*;

2. Domiciliary Care, as defined in Section 13, *Glossary*;

3. multi-disciplinary pain management programs provided on an inpatient basis;

4. private duty nursing;

5. respite care;

6. rest cures;

7. services of personal care attendants; and

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;

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;

4. eye exercise therapy; and

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

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 13, 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;
   - 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; or
   - that exceed Eligible Expenses or any specified limitation in this booklet;

6. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and
7. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

- required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration;
- conducted for purposes of medical research;
- related to judicial or administrative proceedings or orders; or
- required to obtain or maintain a license of any type.
SECTION 8 - CLAIMS PROCEDURES

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

Network Benefits

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

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

Non-Network Benefits

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

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com or calling the toll-free number on your ID card. 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:
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

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

UnitedHealthcare will pay Benefits to you unless:

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

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

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 13, Glossary for the definition of Explanation of Benefits.

Important - Timely Filing of Claims

All claim forms 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 State of Ohio. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.
Claim Denials and Appeals

*If Your Claim is Denied*

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

*How to Appeal a Denied Claim*

If you wish to appeal a denied pre-service request for Benefits or post-service claim as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

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

You or your enrolled Dependent may send a written request for an appeal to:

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

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

<table>
<thead>
<tr>
<th>Types of claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:</td>
</tr>
<tr>
<td>▪ urgent care request for Benefits;</td>
</tr>
<tr>
<td>▪ pre-service request for Benefits;</td>
</tr>
<tr>
<td>▪ post-service claim; or</td>
</tr>
<tr>
<td>▪ concurrent claim.</td>
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</tbody>
</table>

*Review of an Appeal*

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

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.
Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

**Filing a Second Appeal**

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from State of Ohio within 60 days from receipt of the first level appeal determination. State of Ohio must notify you of the appeal determination within 30 days after receiving the completed appeal for a pre-service denial and 60 days after receiving the completed post-service appeal.

You or your enrolled Dependent may send a written request for an appeal to:

Health Benefits Manager  
Ohio Department of Administrative Services  
The Human Resources Division  
30 East Broad 27th Floor  
Columbus, OH 43215

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

**Timing of Appeals Determinations**

Separate schedules apply to the timing of claims appeals, depending on the type of claim.

There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 13, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

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

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>24 hours</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits information to UnitedHealthcare within:</td>
<td>48 hours after receiving notice</td>
</tr>
</tbody>
</table>
### Urgent Care Request for Benefits*

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial request for Benefits is complete, within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:</td>
<td>48 hours</td>
</tr>
<tr>
<td>You must appeal the request for Benefits denial no later than:</td>
<td>180 days after receiving the denial</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
</tr>
</tbody>
</table>

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

### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:</td>
<td>5 days</td>
</tr>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits information to UnitedHealthcare within:</td>
<td>45 days after receiving an extension notice*</td>
</tr>
<tr>
<td>If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial request for Benefits is complete, within:</td>
<td>15 days</td>
</tr>
<tr>
<td>■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal the request for Benefits denial no later than:</td>
<td>180 days after receiving the denial</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>15 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
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</tbody>
</table>
### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Ohio must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal*</td>
</tr>
</tbody>
</table>

Second level appeals can be sent to:

Health Benefits Manager  
Ohio Department of Administrative Services  
The Human Resources Division  
30 East Broad 27th Floor  
Columbus, OH 43215

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
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<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days after receiving an extension notice*</td>
</tr>
<tr>
<td>If UnitedHealthcare denies your initial claim, they must notify you of the denial:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal the claim denial no later than:</td>
<td>180 days after receiving the denial</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>State of Ohio must notify you of the second level appeal decision within:</td>
<td>60 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.
**Concurrent Care Claims**

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

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.
SECTION 9 - COORDINATION OF BENEFITS (COB)

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

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:
- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

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

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

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

**Determining Primary and Secondary Plan – Examples**

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

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

**When This Plan is Secondary**

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

■ the Plan determines the amount it would have paid had it been the only plan involved.
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.

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.

\textbf{Determining the Allowable Expense When This Plan is Secondary}

When this Plan is secondary, 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.

\begin{center}
\textbf{What is an allowable expense?}
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.
\end{center}

\textbf{When a Covered Person Qualifies for Medicare}

\textbf{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; and
- individuals with end-stage renal disease, for a limited period of time.

\textbf{Determining the Allowable Expense When This Plan is Secondary}

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.

\textbf{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. State of Ohio 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.

State of Ohio 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, State of Ohio may recover the amount in the form of salary, wages, or benefits payable under any State of Ohio-sponsored benefit plans, including this Plan. State of Ohio 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, by legal action if necessary.

**Refund of Overpayments**

If State of Ohio 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 State of Ohio if:

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

The refund equals the amount State of Ohio paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help State of Ohio 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, State of Ohio may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. State of Ohio may have other rights in addition to the right to reduce future Benefits.
SECTION 10 - SUBROGATION AND REIMBURSEMENT

What this section includes:
- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery
The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:
- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the plan year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the plan year.

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

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:
- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the Out-of-Pocket Maximum for the plan year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:
- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation
The right to subrogation means 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 Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a
Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

**Right to Reimbursement**

The right to reimbursement means that if a third party causes 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.

**Third Parties**

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 who caused the Sickness, Injury or damages;
- State of Ohio in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

**Subrogation and Reimbursement Provisions**

As a Covered Person, you agree to the following:

- 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.
- 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, or pay any of your associated costs, including attorneys' fees. 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 shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - 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;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement 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.
- 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 may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- 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.
- in 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.
your failure to cooperate with the Plan or its agents 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 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 a third party causes 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 a Covered Person.

the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

**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.
SECTION 11 - WHEN COVERAGE ENDS

What this section includes:
■ Circumstances that cause coverage to end;
■ Conversion from a group policy to an individual policy; and
■ How to continue coverage after it ends.

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

When your coverage ends, State of Ohio 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.

For Employees who were covered (with no lapse) prior to July 1, 2009, your coverage under the Plan will end on the earliest of:

■ the last day of the following month your employment with State of Ohio ends;
■ the date the Plan ends;
■ the last day of the month you stop making the required contributions;
■ the last day of the month you are no longer eligible;
■ the last day of the month UnitedHealthcare receives written notice from State of Ohio to end your coverage, or the date requested in the notice, if later; or

For Employees who were covered after July 1, 2009, your coverage under the Plan will end on the earliest of:

■ the last day of the month your employment with State of Ohio ends;
■ the date the Plan ends;
■ the last day of the month you stop making the required contributions;
■ the last day of the month you are no longer eligible;
■ the last day of the month UnitedHealthcare receives written notice from State of Ohio to end your coverage, or the date requested in the notice, if later; or

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

■ the date your coverage ends;
■ the last day of the month any required contributions cease;
■ the last day of the month UnitedHealthcare receives written notice from State of Ohio to end your coverage, or the date requested in the notice, if later; or
the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;
- you commit an act of physical or verbal abuse that imposes a threat to State of Ohio's staff, UnitedHealthcare's staff, a provider or another Covered Person; or
- you violate any terms of the Plan.

**Note**: State of Ohio has the right to demand that you pay back Benefits State of Ohio paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

### Other Events Ending Your Coverage

Your coverage may also end when any of the following happen. If your coverage is terminated for any of the below reasons you will be provided written notice that coverage has ended on the date State of Ohio identifies in the notice.

- **Fraud, Misrepresentation or False Information** - occurs when there has been fraud or misrepresentation, or the Participant knowingly gave UnitedHealthcare or State of Ohio false material information. Examples include false information relating to another person's eligibility or status as a Dependent. UnitedHealthcare reserves the right to demand that you pay back Benefits State of Ohio paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
- **Material Violation** – occurs when there was a material violation of the terms of the Plan.
- **Threatening Behavior** – occurs when you have committed acts of physical or verbal abuse that pose a threat to State of Ohio's staff or UnitedHealthcare's staff.

### Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 13, Glossary.

**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 State of Ohio if you have questions about your right to continue coverage.
In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

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

**Qualifying Events for Continuation Coverage under COBRA**

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

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage¹</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>State of Ohio files for bankruptcy under Title 11, United States Code.²</td>
<td>36 months</td>
</tr>
</tbody>
</table>

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the
If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA:  
<table>
<thead>
<tr>
<th>For Yourself</th>
<th>For Your Spouse</th>
<th>For Your Child(ren)</th>
</tr>
</thead>
</table>

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

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

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

**How Your Medicare Eligibility Affects Dependent COBRA Coverage**

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

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

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

**Getting Started**

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

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

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

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

■ during Open Enrollment; and
■ following a change in family status, as described under Changing Your Coverage in Section
  1, 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 State of Ohio within 60 days of the
latest of:

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

You or your Dependents must also notify State of Ohio when a qualifying event occurs that
will extend continuation coverage.

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

Once you have notified State of Ohio, 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 your agency’s Human Resources
office 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 contents of the notice must be such that State of Ohio 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 State of Ohio for additional information. The Participant must contact State of Ohio 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 shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- 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 State of Ohio in advance, and providing payment of any required contribution for the health coverage. This may include the amount State of Ohio normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

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

You should call State of Ohio if you have questions about your rights to continue health coverage under USERRA.
SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes:

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

Qualified Medical Child Support Orders (QMCSOs)

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

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, State of Ohio 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 State of Ohio.

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 Ohio

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

- State of Ohio 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 booklet); and
the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

State of Ohio 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 Ohio and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. State of Ohio and UnitedHealthcare will use de-identified data for commercial purposes including research.

**Relationship with Providers**

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

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

State of Ohio is solely responsible for:

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

**Your Relationship with Providers**

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

- are responsible for choosing your own provider;
are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;

must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and

must decide with your provider what care you should receive.

**Interpretation of Benefits**

State of Ohio 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 booklet and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

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

**Information and Records**

State of Ohio 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 Ohio and UnitedHealthcare may request additional information from you to decide your claim for Benefits. State of Ohio and UnitedHealthcare will keep this information confidential. State of Ohio 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 Ohio and UnitedHealthcare with all information or copies of records relating to the services provided to you. State of Ohio 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 Ohio and UnitedHealthcare agree that such information and records will be considered confidential.

State of Ohio 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 Ohio is required to do by law or regulation. During and after the term of the Plan, State of Ohio 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 Ohio 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 Ohio 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. Our designees have the same rights to this information as does State of Ohio.

**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 State of Ohio 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.

State of Ohio'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 State of Ohio 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 State of Ohio 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 State of Ohio and others as may be required by any applicable law.
SECTION 13 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this booklet.

Many of the terms used throughout this booklet 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 booklet, 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 booklet and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and booklet and/or Amendments to the booklet, the Addendum shall be controlling.

**Alternate Facility** – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:
- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

**Amendment** – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by State of Ohio. 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 of Eligible Expenses you must pay for Covered Health Services in a plan year before you are eligible to begin receiving Benefits in that plan year. The Deductible is shown in the first table in Section 4, *Plan Highlights*.

**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.

**Cancer Resource Services (CRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by State of Ohio. The CRS program provides:
- specialized consulting services to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating specific forms of cancer – even the most rare and complex conditions; and
- guidance for the patient on the prescribed plan of care and the potential side effects of radiation and chemotherapy.
**Chiropractic Treatment** – the therapeutic application of chiropractic 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.

**Claims Administrator** – UnitedHealthcare (also known as UnitedHealthcare Insurance Company) 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.

**Coinsurance** – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

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

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

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

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

**Copayment (or Copay)** – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

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

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

**Covered Health Services** – those health services, including services, supplies or Pharmaceutical Products, which State of Ohio determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, substance use disorder, 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 Sections 4 and 5, Plan Highlights and Additional Coverage Details;

provided to a Covered Person who meets the Plan’s eligibility requirements, as described under Eligibility in Section 1, Introduction, and

not identified in Section 7, 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; and

"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 UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this booklet are references to a Covered Person.

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

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

do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or

do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 1, 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 provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

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

**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:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

**Eligible Expenses** – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

<table>
<thead>
<tr>
<th>For:</th>
<th>Eligible Expenses are Based On:</th>
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<tbody>
<tr>
<td>Network Providers</td>
<td>contracted rates with that provider</td>
</tr>
<tr>
<td>Non-Network Providers</td>
<td>If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.</td>
</tr>
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</table>

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

**Emergency** – a serious medical condition or symptom resulting from Injury, Sickness or mental illness, or substance use disorder which:

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

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

**Experimental or Investigational Services** – medical, surgical, diagnostic, psychiatric, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare and State of Ohio make 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); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- 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 and State of Ohio may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare and State of Ohio must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

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

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

**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, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

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

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

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides 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.

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

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

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

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by State of Ohio. The KRS program provides:

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

Lifetime Maximum Benefit – the most the Plan will pay for Benefits during the entire period you are enrolled in this Plan or any other medical plan offered by State of Ohio. The Lifetime Maximum Benefit is shown in the first table in Section 4, Plan Highlights.

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.

**Neonatal Resource Services** - a program administered by UnitedHealthcare or its affiliates made available to you by State of Ohio. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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

**Open Enrollment** – the period of time, determined by State of Ohio, during which eligible Participants may enroll themselves and their Dependents under the Plan. State of Ohio determines the period of time for Open Enrollment.


**Participant** – a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 1, *Introduction*. A Participant must live and/or work in the United States.

**Pharmaceutical Products** – 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 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.


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

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

**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.

**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 booklet does not include mental illness or substance use disorder, regardless of the cause or origin of the mental illness or substance use 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, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

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

**Spouse** – an individual of the opposite gender to whom you are legally married.
**Student** – a person who is enrolled in and attending a recognized course of study or training at:

- an accredited high school; or
- an accredited college or university.

You are no longer a Student as of the last day of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution.

**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 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](http://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 and State of Ohio may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and State of Ohio 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, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and State of Ohio may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness...
or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

- If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and State of Ohio do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and State of Ohio to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

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

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

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

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