The Managed Care Reform and Patient Rights Act of 1999 established rights for Enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions (including external independent reviews).
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet.

Since the description of coverage is not a legal document, for full benefit information please refer to your contract or certificate, or contact your health care plan at the toll free number on the next page. In the event of any inconsistency between your Description of Coverage and contract, subscriber agreement or certificate, the terms of the contract, subscriber agreement or certificate will control.

For general assistance and information, please contact the Illinois Department of Insurance Office of Consumer Health Insurance at (877) 527-9431.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

In addition to the Summary of Benefits enclosed, UnitedHealthcare would like to provide you with the following information:

**Service Area**

The Illinois Counties in our Service Area include the following:

**Medical Management Program**

Enrollees do not have to worry about getting their hospital stay or surgery approved ahead of time when they use a network provider. The goal of UnitedHealthcare's medical management program is to provide quality care in the most appropriate setting and by the most appropriate provider. Medical management involves the process of evaluating the necessity, appropriateness, and efficiency of health care services. Proposed medical care is compared to accepted standards of care.

**Components of UnitedHealthcare’s Medical Management Program:**

Preauthorization - Some procedures, including certain medical and diagnostic procedures, require approval by UnitedHealthcare prior to the time those services are furnished (“preauthorization”). Established criteria are used to determine the appropriateness of those services and the level of care to be provided. If an Enrollee has any question as to whether or not a specific procedure requires preauthorization, he or she should call
UnitedHealthcare at the toll-free number on the back of their ID card or go to the website, www.uhcrivervalley.com.

Failure to obtain preauthorization may result in increased Enrollee responsibility for the costs and expenses associated with the procedure. Such costs and associated expenses will not be applied to any applicable Deductible or Maximum Out-of-Pocket Expense limits.

Hospital or Skilled Nursing Facility Admission Notification - If an Enrollee is admitted to a facility in the HMO network, that facility or the Participating Physician will notify UnitedHealthcare of the admission. However, under the point-of-service option, if an Enrollee is admitted to a facility without preadmission notification, except in a medical emergency, the Enrollee must notify UnitedHealthcare within 24 hours of admission. If the Enrollee fails to make this notification, and the facility stay is longer than medically necessary, the Enrollee will be responsible for all charges associated with all days determined by UnitedHealthcare not to be medically necessary. Such charges will not be applied to any applicable Deductible or Maximum Out-of-Pocket Expense limits.

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

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

Primary Care Physician Selection
At enrollment, each family member will select a Primary Care Physician from our network of providers.

Access to Specialty Care
Referrals are requested by plan providers when an Enrollee is not able to receive the services needed within the network of providers. UnitedHealthcare has developed procedures for pre-authorizing referrals for services to out-of-network providers, for which the coverage will be at the HMO level. All services by Non-Participating Providers, except for emergencies and point-of-service level of benefit, must be pre-authorized by UnitedHealthcare prior to treatment. Most referrals are reviewed and a decision is made by UnitedHealthcare within one working day.

Out-of-Area Coverage
Coverage for medical emergency care that cannot be reasonably postponed until the Enrollee returns home is provided.

Continuity of Treatment
When a provider leaves UnitedHealthcare’s plan, Enrollees currently in active treatment for a chronic or acute medical condition will be allowed an extended transition time to allow for completion of current, active treatment. Extended transition time is defined as the current period of active treatment or 90 days, whichever is shorter. The extended transition time will also include surgical treatment for:

- Surgeries scheduled, but not yet performed.
- Surgical follow-ups for surgeries already performed for a period not to exceed three months.

Enrollees in their second or third trimester of pregnancy will be allowed access through the postpartum period.

Appeals Process
Most Complaints can be resolved satisfactorily on an informal basis by consultation between the Enrollee, UnitedHealthcare staff, and/or the health care practitioner from whom the Enrollee has received services. If an Enrollee’s Complaint is not resolved through informal consultation, the Enrollee or Enrollee’s Authorized Representative may request a formal Appeal. If the Enrollee wants to designate an Authorized Representative to assist him or her with this Appeal Process, this must be done in writing. An Enrollee’s Authorized Representative may not file a formal Appeal without explicit, written designation by the Enrollee.
**Expedited Appeal Procedure for Urgent Care Claims**

For Urgent Care Claims, the Enrollee or Enrollee’s Authorized Representative may contact UnitedHealthcare, orally or in writing, to request expedited consideration of the Enrollee’s formal Appeal.

In determining whether a claim is for urgent care, UnitedHealthcare will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If the request for expedited consideration is denied by UnitedHealthcare, the Appeal will automatically be reviewed by UnitedHealthcare according to the Appeal Procedure. The request for expedited consideration will not be denied if a Physician with knowledge of the Enrollee’s medical condition determines that a claim involves urgent care.

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

UnitedHealthcare will communicate the decision orally to all concerned parties, followed by written notification within three business days.

If the Enrollee or Enrollee’s Authorized Representative disagrees with the decision resulting from the Expedited Appeal Procedure for Urgent Care Claims, he or she may request external review.

The Enrollee or Enrollee’s Authorized Representative has a right to waive UnitedHealthcare’s internal appeal process and request expedited external review when:

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

**Appeal Procedure for Pre-Service and Post-Service Claims that are not Urgent Care Claims:**

For Pre-Service and Post-Service Claims that are not Urgent Care Claims, the Enrollee or his or her designee, guardian, or Attending Physician may request an Appeal by completing a written Appeal Form.

The Appeal Form shall be provided by UnitedHealthcare upon the written or oral request of the Enrollee or Enrollee’s Authorized Representative. The Appeal Form must be completed and filed to UnitedHealthcare within 180 days from the date: (1) the Enrollee received notification of a denial of coverage; or (2) the problem in question occurred. The Appeal Form shall be completed and signed and the facts as alleged shall be binding on the Enrollee. The Appeal Form shall be filed by mail, facsimile, or hand-delivery to UnitedHealthcare, in accordance with the instructions provided with the Appeal Form.

If additional information is needed to evaluate the Appeal, UnitedHealthcare shall within three business days of receiving the Appeal Form notify the Enrollee or Enrollee’s Authorized Representative of the additional information needed.

UnitedHealthcare shall designate a Clinical Peer of the Attending Physician to review the Appeal. Within fifteen business days after receipt of the written Appeal, UnitedHealthcare shall issue a decision orally, followed by a notice in writing, to all parties involved.

If the Enrollee or Enrollee’s Authorized Representative is not satisfied with the decision, and the Appeal was denied for a reason involving medical judgment including, but not limited to the following list, then any involved party may request a standard external review:

- the service, procedure or treatment is not viewed as medically necessary or medically appropriate, or
- denial of specific tests or procedures, or
- denial of referral to specialist physicians, or
- denial of a hospitalization request or length of stay request.
If the Enrollee or Enrollee's Authorized Representative is not satisfied with the decision, and the Appeal was denied for a reason not involving medical judgment, then a request for reconsideration may be filed.

**External Review:**
An Enrollee or any party involved in an Appeal may request external review of the final adverse decision. The provisions of this section shall not be construed to obligate UnitedHealthcare to make payment for any health care service, procedure, or treatment which is not covered under this Subscriber Agreement. An Enrollee or Enrollee's Authorized Representative may request an external review from UnitedHealthcare within 4 months after receipt of a notice of adverse or final adverse determination.

**Exhaustion of Internal Appeal/Grievance Process:**
An Enrollee or Enrollee's Authorized Representative must first exhaust the internal grievance process before requesting an external review, unless:

- he or she requested a standard internal review of an adverse determination but has not received a decision from UnitedHealthcare within 15 business days after receipt of the information, but no later than 30 business day after the request was filed (unless the Enrollee or Enrollee's Authorized Representative agreed to a delay).
- he or she requested an expedited internal review of an adverse determination but has not received a decision from us within 48 hours after receipt of the information (unless the Enrollee or Enrollee's Authorized Representative agreed to a delay).
- UnitedHealthcare waives the exhaustion of the internal grievance process requirement.
- the Enrollee or Enrollee’s Authorized Representative has a right to an expedited review prior to a final adverse determination because:
  - his or her medical condition is such that his or her life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or external review; or
  - the adverse determination is based on the service being determined experimental or investigational, and the Enrollee's provider certifies that the service would be significantly less effective if not promptly initiated.

**Standard External Review:**
UnitedHealthcare will complete a preliminary review of a request within 5 days of receipt to determine whether:

- the Enrollee was a covered person at the time services were requested or provided;
- the services are a Covered Service, but UnitedHealthcare decided they did not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
- the Enrollee or Enrollee's Authorized Representative exhausted the internal grievance process;
- in the case of experimental or investigational services, there is no treatment that is more effective, medically appropriate, or beneficial for the person, as certified by the Enrollee’s physician; and
- the Enrollee or Enrollee’s Authorized Representative has submitted all required information and forms.

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

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

- assign an independent review organization (IRO) from the Director’s list of approved independent review organizations qualified to conduct an external review; and
- notify the Enrollee or Enrollee’s Authorized Representative in writing of the request’s eligibility and the name of the assigned independent review organization (IRO). The notice must also include a statement that he or she may, within 5 business days of the notice receipt, submit in writing to the assigned IRO any additional information to be considered by the IRO in the review. (The IRO is not required to, but may, accept consider additional information submitted after 5 business days).
Within 5 business days of assigning an approved IRO, UnitedHealthcare will send the IRO any documents and information considered in making the adverse determination. If UnitedHealthcare fails to do so, the IRO may terminate the external review and reverse the adverse or final adverse determination in which case the IRO must notify UnitedHealthcare and the Enrollee or Enrollee’s Authorized Representative within 1 business day.

In addition to any documents and information provided by UnitedHealthcare and the Enrollee or Enrollee’s Authorized Representative, an IRO shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the IRO’s clinical reviewer.

The IRO must provide written notice of its decision to UnitedHealthcare and the Enrollee or Enrollee’s Authorized Representative within 5 business days after receiving all necessary information.

- The IRO notice must include a general description of the reason for the external review request, the date it was assigned, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, and the principal reason(s) for its decision.

- For experimental or investigational treatment reviews, the IRO notice must also include descriptions of the factors considered by the IRO in making its decision.

An IRO is not bound by any decisions or conclusions reached in UnitedHealthcare’s utilization review, internal grievance or appeals process.

**Expedited External Review:**
The Enrollee or Enrollee’s Authorized Representative may request, orally or in writing, an expedited external review:

- After receiving a notice of adverse determination from UnitedHealthcare if:
  - the Enrollee’s medical condition is such that his or her life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or standard external review; or
  - The adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.

- After receiving a notice of final adverse determination from UnitedHealthcare if:
  - The final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which the Enrollee received Emergency Services but have not been discharged from the facility; or
  - UnitedHealthcare fails to provide a decision on an expedited internal appeal within 48 hours.

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

- The Enrollee was a covered person at the time services were requested or provided;
- The services are a Covered Service, but UnitedHealthcare decided they did not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and
- In the case of experimental or investigational services, there is no treatment that is more effective, medically appropriate, or beneficial, as certified by the Enrollee’s Physician.

UnitedHealthcare will notify the Enrollee or Enrollee’s Authorized Representative of the eligibility determination. If determined ineligible for expedited external review, UnitedHealthcare will also notify the Enrollee or Enrollee’s Authorized Representative that he or she may appeal UnitedHealthcare’s decision to the Director of Insurance.

If eligible for expedited external review, UnitedHealthcare will:

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

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

The IRO must reach a decision and notify UnitedHealthcare and the Enrollee within 2 business days after receiving all necessary information.

The IRO is not bound by any decisions or conclusions reached in UnitedHealthcare’s utilization review or internal grievance process.

Within 48 hours of rendering its decision, the IRO must provide written confirmation of its decision to UnitedHealthcare and the Enrollee. The confirmation must include the following information:

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

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

**Independent Review Organization (IRO):**
All decisions by the independent review organization are deemed as binding on UnitedHealthcare, and on the Enrollee to the extent that he or she have other remedies available under applicable federal or state law. UnitedHealthcare will approve coverage if the independent review organization reverses the final adverse decision.

If an independent external review decision upholds an adverse determination, you may appeal the independent review organization’s decision to the Department of Insurance until July 1, 2013.

**Appeals to the Department of Insurance:**
Statements informing the Enrollee and any authorized representative that a standard external review (or Expedited External Review) request deemed to be ineligible for review by UnitedHealthcare or their representative may be appealed to the Director by filing a complaint with the Department of Insurance. To appeal initial determinations of ineligibility for standard external review (or Expedited External Review) please contact:

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

Until July 1, 2013 if an external independent review decision upholds a determination that is adverse to the Enrollee, the Enrollee has the right to appeal the independent review organization’s final decision to the Department of Insurance. To appeal the independent review organization’s final decision to the Department please contact:

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

**Enrollee Reconsideration Procedure:**
The Enrollee or Enrollee’s Authorized Representative shall have 30 days from the date an Appeal decision was issued, in which to file a request for reconsideration to the Enrollee Reconsideration Committee of UnitedHealthcare. The Committee meeting shall be held at the UnitedHealthcare home office in Moline, Illinois. Enrollee or Enrollee’s Authorized Representative will be notified that the Enrollee Reconsideration Committee will meet to hear his or her case, and Enrollee or Enrollee’s Authorized Representative will be provided the opportunity to submit additional information and comments in writing. The Enrollee Reconsideration Committee shall resolve the Appeal by
majority vote and shall issue a final written decision to all parties involved within the following timeframes:

- Pre-Service Claim: 15 business days after receipt of the request for reconsideration.
- Post-Service Claim: 30 business days after receipt of the request for reconsideration.

If the Enrollee remains dissatisfied, he or she may bring a civil action in accordance with the rights and limitations of applicable law. If Group is subject to the Employee Retirement Income and Security Act (ERISA), Enrollee may exercise his or her right to bring a civil action under section 502(a) of ERISA.

Upon written request and free of charge, the Enrollee or Enrollee’s Authorized Representative may request copies of all documents relevant to an Appeal or reconsideration. The filing of an Appeal with UnitedHealthcare shall not preclude the Enrollee from filing a complaint with the Department of Insurance nor shall it preclude the Department of Insurance from investigating a complaint pursuant to its authority.

NOTICE OF AVAILABILITY OF THE DEPARTMENT OF INSURANCE

The rules of the Department of Insurance require us to advise the member that if he or she would like to take this matter up with the Illinois Department of Insurance, the Illinois Department of Insurance may be reached at the following addresses and/or phone numbers:

Consumers Call Toll-Free (Within Illinois):

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<th>Health Insurance and HMO Inquiries</th>
<th>Office of Consumer Health Insurance</th>
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<td>(877) 527-9431 (Toll-Free)</td>
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| Office Locations:        | | Office Locations:        |
|-------------------------|-------------------------|
| Springfield office      | Chicago office          |
| 320 W. Washington Street| James R. Thompson Center|
| Springfield, IL  62767-0001| 100 W. Randolph St., Suite 9-301|
| MAIN: (217) 782-4515    | Chicago, IL  60601-3395  |
| TDD/TTY: (217) 524-4872 | MAIN: (312) 814-2420    |
|                         | TDD/TTY: (312) 814-2603 |

You may electronically file your appeal with the Department at http://insurance.illinois.gov/Complaints/file_complaint.asp. Note: External grievance determinations in most cases are not appealable through the Department of Insurance.

IMPORTANT: In the event of any inconsistency between your Description of Coverage and Subscriber Agreement, the terms of the Subscriber Agreement will control.