UTILIZATION REVIEW AMENDMENT TO THE PLAN’S SUMMARY PLAN DESCRIPTION

Effective June 1, 2016, the following change is made to the Plan’s Summary Plan Description (“Plan”).

The “UTILIZATION REVIEW PROVISIONS” section is amended and restated, in its entirety, as follows:

V. UTILIZATION REVIEW PROVISIONS

Utilization Review Process
The Covered Person must call the toll free number given on the identification (id) card to obtain authorization for the services listed under the When To Call provision in this section. Benefits will be reduced or excluded as described in the Reduction of Payment provision in this section, if a Covered Person does not comply with this Utilization Review Process and does not obtain authorization.

A review by the Medical Review Manager does not guarantee that benefits will be paid. Payment of benefits will be subject to all the terms, limits and conditions in this Plan.

The review process must be repeated if treatment is received more than 30 days after review by the Medical Review Manager or if the type of treatment, admitting Health Care Practitioner or facility differs from what the Medical Review Manager authorized.

A determination by the Medical Review Manager does not alter, limit or restrict in any manner the attending Health Care Practitioner’s ultimate patient care responsibility.

Utilization Review Procedures
To obtain authorization, the Covered Person must contact the Medical Review Manager by calling the toll free number on the ID card. Please have all of the following information on hand before calling:

1. The group number for this Plan.
2. The Health Care Practitioner’s name and telephone number.
3. The service, procedure and diagnosis.
4. The proposed date of admission or date the service or procedure will be performed.
5. The facility’s name and phone number.

The Medical Review Manager may review a proposed service or procedure to determine: Medical Necessity; whether it is a Cosmetic Service or an Experimental or Investigational Service; location of the treatment; and length of stay for an Inpatient confinement. As part of the review process, the Medical Review Manager may require, at the Plan’s expense, a second opinion from a Health Care Practitioner recommended by the Medical Review Manager.

When To Call
Contact the Medical Review Manager for authorization of the following services.
1. **Inpatient Confinements:** Call Us to obtain authorization for an admission to, or transfer between, an Acute Behavioral Health Inpatient Facility, an Hospital, an Acute Medical Rehabilitation Facility, a Behavioral Health Rehabilitation and Residential Facility, a Subacute Rehabilitation Facility, a Hospice facility, a Nursing Facility or any other Inpatient confinement that will exceed 24 hours as follows:

   a. Non-Emergency Confinements: Call at least 7 business days prior to an Inpatient admission for a non-emergency confinement that will exceed 24 hours in length.
   
   b. Emergency Confinements: Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Confinement that will exceed 24 hours in length. The Covered Person must provide or make available to the Medical Review Manager the full details of the Emergency Confinement. Covered Emergency Treatment will be provided without the requirement for prior authorization, regardless of whether the provider is a Participating Provider or not.
   
   c. Maternity Confinements: If the Inpatient confinement exceeds 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated caesarean section delivery, the Covered Person must call prior to the end of the confinement, or as soon as reasonably possible. Any other Inpatient confinements that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions above.

2. **Outpatient Procedures**: Call Us to obtain authorization for the following procedures that are performed as an Outpatient in a Hospital, an Acute Medical Rehabilitation Facility, a Free-Standing Facility, a Subacute Rehabilitation Facility, an Urgent Care Facility or in a Health Care Practitioner’s office. Call at least 7 business days prior to receiving any non-emergency Outpatient services that are listed below. Call within 24 hours, or as soon as reasonably possible, after receiving Emergency Treatment involving any of the Outpatient services listed below.

   a. Any surgical procedures.
   
   b. Invasive cardiology services for diagnostic or therapeutic cardiac procedures, except cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).
   
   c. Invasive radiology services for diagnostic or interventional purposes.
   
   d. Dialysis.
   
   e. Chemotherapy.
   
   f. Radiation therapy, including, but not limited to:
      
      i. Brachytherapy (internal radiation therapy);
      
      ii. External beam radiation therapy (EBRT);
      
      iii. Image guided radiotherapy (IGRT);
      
      iv. Intensity-modulated radiotherapy (IMRT);
      
      v. Ionizing radiation;
      
      vi. Proton therapy (proton beam therapy);
      
      vii. Stereotactic radiosurgery (SRS); or,
      
      viii. Three-dimensional conformal radiation therapy (3DCRT).
   
   g. Implants, prosthesis and/or replacement of any joint, including but not limited to spine, knee and hip.
Authorization is not required for laboratory services, endoscopies and non-invasive Diagnostic Imaging services, such as x-rays, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), ultrasound or nuclear medicine scans.

3. **Diagnostic Imaging Services and Laboratory Services:** Call at least 7 business days prior to receiving any of the following services:
   a. Capsule Endoscopy;
   b. Computed Tomography (CT);
   c. Magnetic Resonance Angiogram (MRA);
   d. Magnetic Resonance Imaging (MRI);
   e. Positron Emission Tomography (PET) Scan;
   f. Scintimammography; or,
   g. Peripheral Bone Density Test – Heel Only (including, but not limited to: Peripheral Dual Energy X-ray Absorptiometry (pDXA); Single Energy X-ray Absorptiometry (SX)A; or Quantitative Ultrasound (QUS)).

4. **Transplants:** Call at least 7 business days prior to any transplant evaluation, testing, preparative treatment or donor search.

5. **Pharmaceuticals:** Call at least 7 business days prior to obtaining any drug regimen for which the Drug List requires authorization, including but not limited to beginning a course of non-intravenous injectable drug therapy, or intravenous injectable parenteral drug therapy, such as chemotherapy. The Drug List identifies which Prescription Drugs require prior authorization.

6. **Durable Medical Equipment and Personal Medical Equipment:** Call at least 7 business days prior to the purchase or rental of Durable Medical Equipment and Personal Medical Equipment with a purchase price in excess of $1,500.

7. **Home Health Care and Hospice Care:** Call at least 7 business days prior to beginning Home Health Care or Hospice Care.

8. **Outpatient Behavioral Health and Substance Abuse Services:** Call at least 7 business days prior to receiving Outpatient services for Behavioral Health or Substance Abuse, including, but not limited to:
   a. Residential treatment center (RTC) admission;
   b. Partial hospitalization programs (PHPs);
   c. Intensive outpatient programs (IOPs);
   d. Psychological testing;
   e. Neuropsychological testing;
   f. Psychiatric home care services;
   g. Detoxification; or,
   h. Applied behavioral analysis (ABA).

**Continued Stay Review**
The Medical Review Manager may request additional clinical information during an Inpatient confinement. Failure of the Health Care Practitioner or facility to provide the requested information will result in non-authorization of continued Inpatient confinement. No benefits will be considered until the additional information is received by the Medical Review Manager.

No benefits will be paid for the days of Inpatient confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Medical Review Manager based on review of the additional information provided.

**Reduction Of Payment**
The effect of noncompliance with the utilization review process is:

1. No benefits will be paid under this Plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment or donor search.

2. Benefits will not be paid for any Specialty Pharmaceuticals that are not authorized by the Medical Review Manager.

3. If authorization is not obtained for the Covered Person’s course of treatment for other services as provided in the When to Call provision above, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment.

   Examples of failure to obtain authorization include:

   a. The Covered Person fails to obtain authorization for the treatment from the Medical Review Manager.

   b. The Covered Person does not contact the Medical Review Manager within the required timeframe.

   c. The type of treatment, admitting Health Care Practitioner or facility differs from what was authorized by the Medical Review Manager.

   d. The treatment is Incurred more than 30 days after review by the Medical Review Manager.

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Coinsurance, Copayment, Deductible, or Out-of-Pocket Limit.

**Utilization Review Decisions**
The Medical Review Manager, upon notification, will determine (in consultation with the Covered Person’s Health Care Practitioner) whether or not an Inpatient confinement, surgery, or other medical care is Medically Necessary. The Medical Review Manager will certify all such medical care that is determined to be Medically Necessary or suggest other care options that may exist for treatment of the condition. For Inpatient admissions, the Medical Review Manager will also certify the number of days of confinement that are considered to be Medically Necessary. If the attending Health Care Practitioner feels, due to extenuating circumstances, that additional days are required to treat the condition properly, he or she may contact the Medical Review Manager to discuss the Medical Necessity of an extended length of stay and request certification for additional days. Any medical care or confinement that is not determined to be Medically Necessary will not be certified and will not be eligible for benefits. The Medical Review Manager will notify the Covered Person promptly of its determination. It
will also notify the Medical Facility or Behavior Health Facility and the Covered Person’s Health Care Practitioner.

If the Covered Person or his/her Health Care Practitioner do not agree with the decision of the Medical Review Manager, the decision may be appealed according to the appeal provisions listed in the Claim Provisions section.

**Maternity Management Program**

Upon confirmation of a pregnancy, all expectant mothers are asked to participate in a maternity management program aimed at keeping the Covered Person and the unborn child healthy. The primary objective of the maternity management program is to anticipate the possibility of a high or moderate risk pregnancy and help coordinate effective medical care.

It is highly recommended, but not a requirement of the Plan, that expectant mothers call the Medical Review Manager during the first trimester of pregnancy, or upon confirmation of pregnancy. At this time, a Registered Nurse (RN) will ask questions about the expectant mother’s general health and medical history. This information will be discussed with the Covered Person’s Health Care Practitioner to help determine the risk factor of the pregnancy.

No preauthorization is required. To participate, contact the Medical Review Manager using the toll free number on Your identification (ID) card.

All other sections and provisions of the Summary Plan Description will remain in effect. This Utilization Review Amendment to the Plan’s Summary Plan Description is hereby adopted in its entirety by the Plan Sponsor.