PREMIER
MEMBER HANDBOOK

JOHN DEERE

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Introduction

Welcome to your Premier Active Member Handbook. Medicare members, your handbook is provided by UnitedHealthcare and is entitled *Plan Details*.

This handbook contains important information about your health benefits and how to access health care services, and using the Premier provider network from UnitedHealthcare®. This guide also describes additional programs that can help you meet your health goals and choose the right provider for the right type of care.

While you and your family always have the choice of what services you receive and who provides your health care, your benefits are generally greater when you use a Premier network provider. It is important to understand how benefit coverage differs for network and out-of-network care.

Please familiarize yourself with the contents of this handbook, and keep it handy for your reference.

This handbook can be accessed online from the benefit portal at www.yourbenefitsresources.com/deere by selecting Plan Information from the quick links on the home page.

If you have any questions about your health care services, feel free to call myHEALTH at 1-888-JDEERE1 (533-3731). This number is also located on the back of your medical ID card.

You may also call the John Deere Benefits Center at 1-844-689-7833.

UnitedHealthcare (UHC) myHEALTH

Call UHC myHEALTH whenever you need information about Premier benefits or the provider network.

myHEALTH Phone Hours

myHEALTH representatives are available Monday through Friday from 7 a.m. until 8 p.m. in the member's local time zone.

myHEALTH Number

You can reach a myHEALTH representative at 1-888-JDEERE1 (533-3731).

Special Language Needs

Representatives can also assist members who are hearing-impaired. Call your TDD service and provide the customer service number above.

Website

You can also find important information about your provider network, claim history and prescription drug benefits, as well as useful tools to help you make informed health care decisions, at myuhc.com.

Accessing health care services

The Premier network has been built to provide you with quality health care through the appropriate number and types of contracted health care providers.

UHC follows federal standards, set by the U.S. Department of Health and Human Services, to help ensure that each provider network is sufficient to meet the projected needs of the population in terms of the number and type of providers, as well as the accessibility of those providers to health plan members.

UHC has established a quality, cost-effective network for each service area. Some hospitals and physicians in your community are not included in this network. Hospitals and physicians in surrounding communities may be included in the network, if they meet network standards and terms.

Be assured that the network is sufficient to provide you and your dependents with adequate access to covered health care services. If covered services are not available within the provider network, you may obtain a preauthorized GAP Exception to use out-of-network services at network benefit levels (see GAP Exception Process on page 14).

Obtaining network vs. out-of-network services

It is important that you refer to your current provider information to see which doctors, hospitals, and other providers are within the Premier network. Using these network providers will ensure that you are minimizing your out-of-pocket expenses for covered services.

With a few exceptions (e.g., Emergency care and Urgent Care Services), services from physicians and hospitals that are not included in the Premier network are considered "out-of-network" services. These out-of-network services will result in higher out-of-pocket expenses unless a preauthorized GAP Exception is obtained (see GAP Exception Process on page 14).

Network providers

It is important that you refer to myuhc.com to see which doctors, hospitals, and other providers are within the Premier network. Keep in mind that the network changes periodically. For the most current provider information, visit myuhc.com. You may also call a myHEALTH representative at 1-888-JDEERE1 (533-3731) to assist you in finding a provider.

Some hospitals and physicians in your community are not included in the Premier network. Hospitals and physicians in surrounding communities may be included in the network if they meet network standards and terms.

Point-of-Service Benefits for Out-of-Network Services

How do benefit payments work?

When using the Premier network, you have no deductible or coinsurance requirements for covered network services. For in-network covered medical services excluding prescription drugs, an active employee has the following in-network copayments for non-preventive care: primary care physician office visit $40, specialty physician office visit $50, emergency room visit $150, outpatient surgery $100, and inpatient hospital admission $150. If you are a retiree or LTD employee, refer to your Summary Plan Description for details on your copayments. The plan then pays 100 percent of all covered network medical services.

If you choose to obtain medical services outside of the Premier network without a preauthorized GAP Exception, those services will be covered at a reduced benefit level or may not be covered at all. These benefits are referred to as Point-of-Service (POS) Benefits.

The plan does not pay out-of-network benefits for:

- Routine physicals
- Mammograms or Pap tests
- Well-child care or immunizations
- Home health care
- Organ transplants
- Durable medical equipment and prosthetic devices

Here's how the out-of-network process works under the Premier network:

- When you use out-of-network providers without a preauthorized GAP Exception, you first pay a $250-per-individual ($500-per-family) annual deductible before the plan pays benefits.
- Once you meet your deductible, the plan pays 80 percent of the Maximum Allowable Benefit (MAB). This amount is also known as the Maximum Non-Network Reimbursement Program (MNRP). See below for details.
- Deductible and coinsurance payments go toward meeting your annual Out-of-Pocket Maximum requirement ($2,500 individual/$5,000 per family).
- If your Point-of-Service out-of-pocket expenses for out-of-network care reach $2,500 (or $5,000 per family) in a calendar year, the plan pays 100 percent of the MAB/MNRP for the rest of the year. You are responsible for paying the provider any charges that exceed the MAB /MNRP. The difference between the MAB /MNRP and your billed charges do not count toward the Out-of-Pocket Maximum.

The Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP) is a vital part of determining your out-of-network benefit.

UHC uses the MAB/MNRP to determine the benefits payable for covered medical services you receive from out-of-network providers without a preauthorized GAP Exception.

In addition to deductibles and coinsurance payments that apply to out-of-network services, you are responsible for paying the cost of medical services that exceed the MAB/MNRP.

To determine your potential financial responsibility for out-of-network services, you need to know the MAB/MNRP for those services. Contact UHC Customer Service to learn the MAB/MNRP for out-of-network covered services you expect to receive.

UHC myHEALTH representatives can also provide you with more detail about how the MAB/MNRP is calculated.

Premier network

With Premier, you have no deductible or coinsurance requirements for network services.

- If covered services are not available within the provider network, preauthorized GAP Exceptions for out-of-network services covered at network benefit levels may be made.
- Remember that you receive benefit coverage for only some out-of-network medical services.
- Under the Point-of-Service benefits, you are responsible for paying provider charges that exceed the MAB/MNRP.
- Amounts you pay that exceed the MAB/MNRP do not apply toward your Out-of-Pocket Maximum.

Remember, you have no deductible or coinsurance requirements when using Premier network providers, and you are not responsible for charges that exceed contracted rates. The MAB/MNRP limitation only applies to services received from out-of-network providers without a preauthorized GAP Exception (other than emergency care and Urgent Care Services).

Examples of member costs for out-of-network care

Imagine Rachel is one of your co-workers. During the course of the calendar year, she has the option of choosing Premier network providers or out-of-network providers for her medical care.

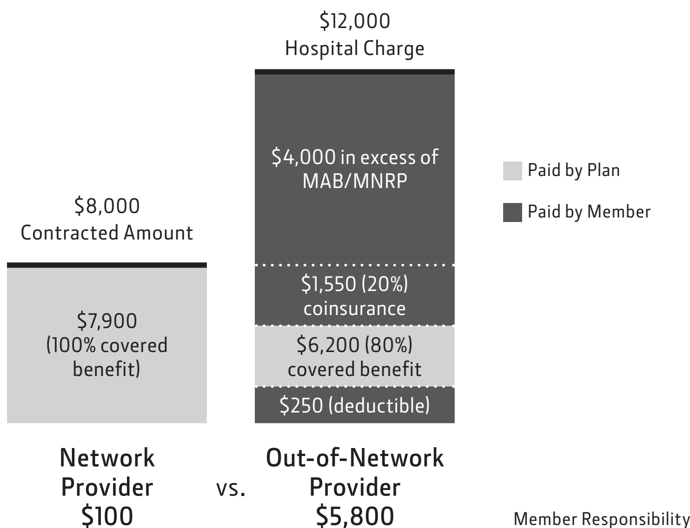
The following three examples illustrate the significant differences in out-of-pocket costs Rachel would incur if she chose to use her Point-of-Service benefits rather than getting care from network providers.

Note: The charges in these examples are fictional and are for illustrative purposes only. Actual provider charges may vary. An individual network provider's contracted amount may be higher or lower than the Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP).

EXAMPLE 1 - Individual Coverage (January 2022)		
Hospital Hernia Repair (not including physician charges)		
	Network	**Out-of-Network**
Provider charge	N/A	$12,000
Contracted amount	$8,000	N/A
MAB/MNRP	N/A	$8,000
Deductible	N/A	$250
Coinsurance basis (MAB/MNRP less deductible)	N/A	$7,750
Member coinsurance (20% of $7,750)	$0	$1,550
Outpatient Surgery Copay	$100	N/A
PLAN PAYS	**$7,900**	**$6,200**
Member pays:		
Deductible	$0	$250
Coinsurance	$0	$1,550
Copay	$100	$0
Excess of MAB/MNRP	$0	$4,000
TOTAL MEMBER PAYS	**$100**	**$5,800**
Rachel's amounts fulfilled to date:		
Deductible	N/A	$250
Out-of-Pocket Maximum*	$100	$1,800

** Total of any copayment, deductible, and coinsurance paid.*

EXAMPLE 1 - Breakdown



Example 1

In January, Rachel decides to use an out-of-network hospital for hernia repair. In this example, the out-of-network hospital's charge for the service is $12,000 and the MAB/MNRP is $8,000. Rachel will be responsible for the initial $250 deductible. That leaves the basis for calculating coinsurance at $7,750 ($8,000 MAB/MNRP - $250 deductible).

The plan will pay $6,200 (or 80 percent of the $7,750), and Rachel is responsible for $1,550 (or 20 percent of the $7,750) in coinsurance.

Rachel will also be responsible for all charges in excess of the $8,000 MAB/MNRP ($12,000 out-of-network charge - $8,000 MAB/MNRP). $4,000 is the amount in excess of MAB/MNRP.

In this example, Rachel has accumulated $1,800 ($250+$1,550) toward her $2,500 annual Out-of-Pocket Maximum. The $4,000 in excess of the MAB/MNRP does not apply to her Out-of-Pocket Maximum.

If Rachel had chosen a network provider for these services, her out-of-pocket costs could have been $100 for the outpatient surgery copay.

You can view tables on the following pages to see how the costs break down for two other examples of medical services and plan payment under your benefit plan.

Example 2

In the summer, Rachel injures her right knee and is later told she will require arthroscopic surgery. Since she already has met her $250 deductible for the year, and paid $1,550 in coinsurance for hernia repair, she will meet her Out-of-Pocket Maximum of $2,500 per individual and $5,000 per family per calendar year by paying the remaining $700 of the coinsurance costs.

However, because the medical costs for the surgery exceed the MAB/MNRP, Rachel is responsible for paying the amount in excess of the MAB/MNRP.

Again, if Rachel had chosen a network provider, her out-of-pocket costs would be $100 for the outpatient surgery copay.

Note: The charges in these examples are fictional and are for illustrative purposes only. Actual provider charges may vary. An individual network provider's contracted amount may be higher or lower than the Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP).

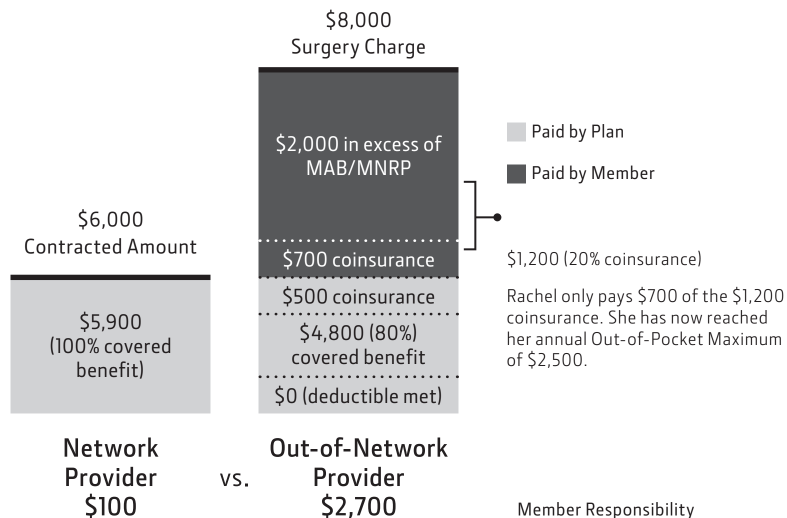
EXAMPLE 2 - Individual Coverage (June 2022)

Arthroscopic Surgery at outpatient surgery center (not including physician charges)

	Network	Out-of-Network
Provider charge	N/A	$8,000
Contracted amount	$6,000	N/A
MAB/MNRP	N/A	$6,000
Deductible (already met)	N/A	$0
Coinsurance basis (MAB /MNRP less deductible)	N/A	$6,000
Member coinsurance*	$0	$700
Outpatient Surgery Copay	$100	N/A
PLAN PAYS	**$5,900**	**$5,300**
Member pays:		
Deductible*	$0	$0
Coinsurance	$0	$700
Copay	$100	$0
Excess of MAB/MNRP	$0	$2,000
TOTAL MEMBER PAYS	**$100**	**$2,700**
Rachel's amounts fulfilled to date:		
Deductible	N/A	$250
Out-of-Pocket Maximum*	$200	$2,500

** NOTE: Rachel has already met her annual Point-of-Service deductible. In this example, Rachel met her individual Out-of-Pocket Maximum (OOPM) for the year. She pays only $700 of the $1,200 in coinsurance because that is the amount remaining to satisfy her OOPM ($1,800+$700; refer to Example 1). The plan pays amounts over your OOPM up to MAB/MNRP.*

EXAMPLE 2 - Breakdown



Note: The charges in these examples are fictional and are for illustrative purposes only. Actual provider charges may vary. An individual network provider's contracted amount may be higher or lower than the Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP).

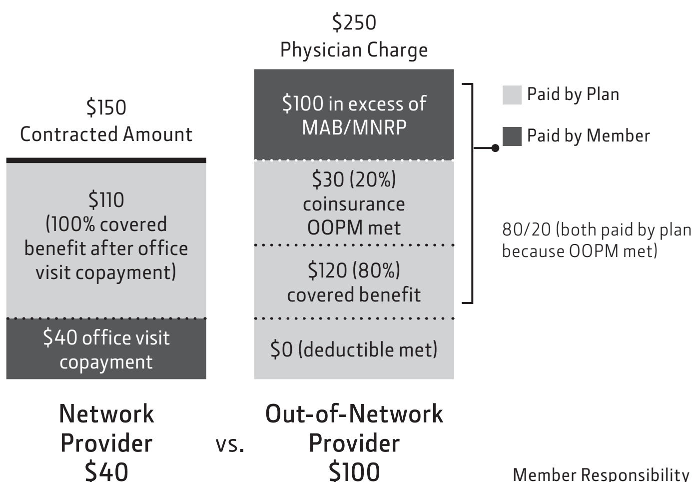
EXAMPLE 3 - Individual Coverage (November 2022)

Non-routine office visit

	Network	Out-of-Network
Provider charge	N/A	$250
Contracted amount	$150	N/A
MAB/MNRP	N/A	$150
Office visit copayment	$40	N/A
Deductible	N/A	$0
Coinsurance basis (MAB/MNRP less deductible)	N/A	$150
Member coinsurance	$0	$0
PLAN PAYS	**$110**	**$150**
Member pays:		
Deductible*	$0	$0
Coinsurance*	$0	$0
Excess of MAB/MNRP	$0	$100
Copayment	$40	$0
TOTAL MEMBER PAYS	**$40**	**$100**
Rachel's amounts fulfilled to date:		
Deductible	N/A	$250
Out-of-Pocket Maximum*	$240	$2,500

** Rachel has already met her annual Point-of-Service deductible and Out-of-Pocket Maximum (OOPM). (Refer to EXAMPLES 1 and 2.)*

EXAMPLE 3 - Breakdown



Example 3

Later in the year, Rachel gets sick and goes to see an out-of-network doctor. Since she has already met her Out-of-Pocket Maximum for the year, Rachel will not have any coinsurance or deductible payments. She is only responsible to pay the difference between the MAB/MNRP and the doctor's charge for her visit.

Summary of Rachel's Point-of-Service Usage

By choosing out-of-network services, Rachel is responsible for $8,600 in out-of-pocket costs for the year. If she had chosen network providers for those same services (as shown in the previous examples), her total out-of-pocket cost would have been $240.

Outside the Service Area

If you or your covered family members need emergency room care, you're covered. You should go to the closest emergency room to seek care for initial treatment. Then, contact your regular physician within 48 hours or on the first business day following treatment to arrange your follow-up care.

Remember that follow-up care and/or elective care must be done by a network provider. If this care is done outside of the network, the services will not be covered at your network benefit level or may not be covered at all.

Emergency room care and urgent care facility services are covered for you and your family when you spend time traveling or visiting outside the service area. This includes coverage for dependent college students. Emergency room care is covered at 100% of the allowed covered charge (to the nearest facility) after a $150 copayment for initial medical care. The copay is waived if admitted to observation room confinement or acute inpatient.

When you receive care in an emergency room, the provider will likely be able to file a claim with UHC if you present the provider with your medical ID card. If the provider is not able to submit a claim to UHC, you may pay for your charges and be reimbursed (according to your benefit plan) when you get home.

Access a claim form at myuhc.com or send an itemized bill that includes the following information:

– Date(s) of service

– Description of services obtained

– Procedure codes for services obtained

– Provider name, address, and tax identification number

Please mail the medical claim to the address listed below. This address can also be found on the back of your ID card.

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Be sure to include your name, member ID, and daytime telephone number.
Payment will be made to you based on your benefit plan.

Emergency Care

Emergency care is needed when a medical condition shows itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or with respect to pregnant women, the health of the pregnant woman or her unborn child), serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. Emergency room care is covered at 100% of the allowed covered charge (to the nearest facility) after a $100 copayment for initial medical care. The copay is waived if admitted to observation room confinement or acute inpatient.

Emergency rooms are designed for people with serious health events. Go to the emergency room for conditions such as:

- Heavy bleeding
- Large open wounds
- Sudden change in vision
- Chest pain
- Sudden weakness or trouble talking
- Major burns
- Spinal injuries
- Severe head injury
- Difficulty breathing
- Major broken bones

Be sure to call 911 or go to the emergency room if you or someone you know seems to be having a heart attack, stroke, difficulty breathing or other perceived life-threatening event.

Q: If I am in the health plan service area and need emergency care, what should I do?

A: If you need emergency room care for a serious or life-threatening illness or injury, you should use 911 services when appropriate and/or seek care from the nearest hospital. After treatment, contact your regular physician within 48 hours or on the next business day to arrange your follow-up care.

Q: What if my physician's office is closed?

A: If you do not feel the situation requires emergency care, call your physician's office for information on how to contact the network physician on call, and follow his or her instructions for treatment.

Emergency room care and urgent care facility services are covered for you and your family when you spend time traveling or visiting outside the service area. This includes coverage for dependent college students.

If you're not sure whether your situation merits a visit to the emergency room, you can call our contracted myHEALTH service and speak with a registered nurse 24 hours a day.

- myHEALTH (TTY/TDD available): 1-888-533-3731

GAP Exception Process

Keep the following terms in mind when reading this information. Network providers are those included within the Premier network. They include primary care physicians (PCPs), as well as specialists and hospitals. Out-of-network providers are those not included in the Premier network.

Premier

In the Premier network, you have the option to see network specialists without a referral from your PCP. That means you can go to any specialist included in the Premier network.

Remember to confirm the specialist you see is a network provider before making your appointment. You can do this by checking your Provider Directory online at myuhc.com or by calling 1-888-JDEERE1 (533-3731).

NOTE: *In the rare instances that needed treatment is not available through a network specialist, your physician will request preauthorization for an out-of-network GAP Exception from UHC. Coverage (payment) authorization must be approved before out-of-network services are received, except emergency care or Urgent Care Services.*

Out-of-Network

You can choose to see out-of-network providers without a referral for covered benefits. However, these visits will be covered at a lesser benefit level. For example, if you use an out-of-network provider in a non-emergency situation, only 80 percent of the MAB/MNRP after you pay a $250 deductible for individual only coverage or $500 deductible for family coverage. You will also be responsible for the amount billed above MAB/MNRP. This could result in significant out-of-pocket expense to you. Remember, certain services are not covered out-of-network (for example, preventive care, durable medical equipment, prosthetic devices, home health care, and organ transplants). Refer to Point-of-Service section on page 6.

IMPORTANT NOTICE: *Medical providers are independent contractors, not employees or agents of the health plan. Members and their medical providers, not the health plan, decide what medical care members receive and how they receive it. UHC only determines what medical care will be paid for under your benefit plan.*

Access and Availability Guidelines

The following guidelines have been developed to establish standards for access to primary care physicians (PCPs). Health plan members expect timely access to health care from network providers. Establishment of standards for access allows for measurement of physician performance against standards over time. Accessibility reviews are performed to identify potential problems related to appointment availability, waiting times, and telephone procedures that may result in the delayed delivery of care and services.

Arrangement of Medical Services

Each network primary care physician will provide (or arrange to provide) all necessary services to members on a 24-hour-per-day, 7-day-per-week basis.

Standard Levels of Service

Preventive: Well exams for adults and children and scheduled follow-up exams. Patients are normally free of symptoms.

Routine: Exams for non-urgent symptomatic conditions.

Emergency care is needed for conditions such as: heavy bleeding, large open wounds, sudden change in vision, chest pain, sudden weakness or trouble talking, major burns, spinal injuries, severe head injury, difficulty breathing and major broken bones.

Be sure to call 911 or go to the emergency room if you or someone you know seems to be having a heart attack, stroke, difficulty breathing or other perceived life-threatening event.

Emergency care or Urgent Care Services will be covered when such services are medically necessary and immediately required:

- as a result of an unforeseen illness, injury, or condition while you are out of the service area; or
- while in the service area, it is not reasonable given the circumstances to obtain services through your network primary care physician. You must use a network urgent care facility.

Geographic Accessibility

The network was built to provide you with quality health care providers who meet the access and availability guidelines from the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

With the Premier network, you have no deductible or coinsurance requirements for network services.

- myuhc.com should be used to check for providers in the network or call 1-888-JDEERE1 (533-3731).

Appointment Scheduling Guidelines

- Preventive physical exam appointments for patients with no acute problems should be scheduled within three (3) weeks.
- Well-child care appointments should be scheduled within three (3) weeks.
- General medical exams (including pelvic exams with Pap smears) should be scheduled within three (3) weeks. Exception: Medicare within 20 days.
- Mammograms should be scheduled within three (3) weeks.
- Appointments for urgent complaints that can be handled in the office should be scheduled within 24 to 48 hours. Patient phone calls for urgent complaints may result in either an appointment to be seen within 24 to 48 hours or a referral for telephone follow-up as described in Waiting Time Guidelines (see below).
- Medical emergencies should be seen immediately.
- Appointments with referred providers should be scheduled within three (3) weeks, except when the referring primary care physician (PCP) requests an earlier appointment.
- Routine care (for non-urgent symptomatic conditions) appointments with PCPs should occur within two (2) weeks.
- Request-to-procedure time frames for X-ray, lab, and other procedures should be consistent with clinical urgency but not greater than 14 days for routine services and not greater than 48 hours for Urgent Care Services.
- Access should be provided after hours through on-call coverage.
- Behavioral Health Standards:
  - Life-threatening emergencies should be seen immediately.
  - Non-life threatening emergencies should be seen within six (6) hours.
  - Urgent care appointments should be scheduled within 48 hours.
  - Routine care appointments should be scheduled within ten (10) working days.

Waiting Time Guidelines

- A physician or his/her designee should be available 24 hours a day/seven days a week for emergency care.
- After-hours calls to the answering service for urgent problems are to be returned as soon as possible.
- Non-urgent phone calls to the physician during regular office hours are to be returned the same day by the physician or designee. The physician's office staff should set an expectation with the caller as to when the call will be returned.
- Urgent phone calls to the physician during regular office hours are to be returned by the physician or staff designee as soon as possible.
- Patients with scheduled appointments are to be seen by the practitioner within thirty (30) minutes of their scheduled appointments.
- Waiting time for procedures (lab, X-rays) must not exceed thirty (30) minutes on the day of the procedure.

Your Pharmacy Benefits

The UHC Prescription Drug list

A Prescription Drug List (PDL) is a list of a health plan's preferred medications that have been reviewed for quality and cost-effectiveness. Having a PDL is one way we help arrange for high-quality medications to be available at the most affordable price. You can view the most current PDL online at myuhc.com.

Tiered Copayment

Drugs on the PDL are arranged in tiers by the UnitedHealthcare PDL Management Committee. Drugs in the lower tiers represent your lower copay options, while drugs in upper tiers are your higher copay options. Please refer to your individual benefits for further explanation.

You are encouraged to choose generic medications whenever possible in order to take advantage of a lower copayment. You will be responsible for the copayment for each covered prescription. You can either purchase up to a 34-day supply at a network retail pharmacy, or up to a 100-day supply for drugs on the 100-day maintenance list from OptumRx.

Pharmacy Policies

When filling a prescription, it is important to be aware of the policies of your health plan with regard to certain prescriptions. In most cases, you simply pay your copayment and receive your prescription. However, some drugs require prior authorization, may have restricted indications, or may have quantity restrictions.

- Generic medications are as safe and effective as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) requires that generic medications have the same active ingredients as their brand-name counterparts and work the same way in the body.
- Generic drugs are typically much less expensive because they don't involve the research, advertising, and marketing costs associated with brand-name drugs.
- If you use a non-network pharmacy, you must submit the receipt to UHC for reimbursement. Your reimbursement will not exceed the benefit available through a Participating Pharmacy.

- A Prescription Drug List (PDL), is simply a list of a health plan's preferred medications that have been reviewed for quality and cost-effectiveness.
- Prescription drugs by far make up the fastest growing segment of medical costs. Having a PDL is one way UnitedHealthcare helps to see that high-quality medications are available at the most affordable price.

PDL Questions and Answers

Q: What is a Prescription Drug List (PDL)?

A: A Prescription Drug List (PDL) list is simply a list of a health plan's preferred medications that have been reviewed for quality and cost-effectiveness. Take a copy of the PDL with you when you visit your physician and ask him or her to consult it when prescribing. Your physician will know which of these quality, cost-effective drugs are appropriate for you.

Q: How will using a PDL benefit me?

A: In some instances, using a PDL drug may result in a lower copayment or the ability to obtain a larger quantity of a long-term medication. Many drugs listed (those listings beginning with a lower-case letter) are available in generic form, the best value in prescription medications. Overall, using drugs on the list is one way to help you manage your health care costs and ensure that high-quality medications are available at the most affordable price.

Q: Why are PDLs used?

A: Having a PDL is one way UnitedHealthcare helps arrange for high-quality medications to be available at the most affordable price. Where possible, UHC contracts with pharmaceutical manufacturers to receive discounts and rebates. These discounts and rebates help us to better manage prescription drug costs.

Q: How are drugs on the PDL selected?

A: The comprehensive list of PDL drugs is carefully selected by a committee of practicing primary care physicians, specialty physicians, and pharmacists. Drugs are not selected on the basis of cost alone; the committee considers effectiveness, side effect profiles, potential for drug interactions, ease of administration, and physician preference first. Cost is considered only when several quality products are available that satisfy a particular need. The committee meets regularly to review new medications and make sure the list reflects currently accepted medical practices.

Q: Who can I call if I have other questions about prescriptions?

A: Call UHC at 1-888-JDEERE1 (533-3731).

Home Delivery Pharmacy Program

Your prescription medication can be delivered right to your door through the home delivery pharmacy program. It's ideal for maintenance medications – prescription drugs taken on a regular basis to manage conditions like arthritis, high blood pressure, or asthma. You'll save time, money, and trips to your pharmacy.

After you and your physician have determined a maintenance drug (listed on the 100-day maintenance list) that works for you, ask your doctor to write two prescriptions:

- The first prescription should be written for up to a 34-day supply with refills. Have this prescription filled at a local network pharmacy.
- The second prescription must be written for you to receive a 100-day maintenance supply with the three refills at one time. This prescription should be sent to OptumRx.

After filling your initial prescription at retail, you should send the mail-order prescription two to three weeks prior to needing additional medication. This will allow for processing time and mail delivery.

Payment

Payment for applicable copayments must be included with the prescription and completed order form. OptumRx accepts Visa, MasterCard, American Express, Discover Card, check, or money order. Your order will be delayed until payment is received.

Shipping

There is no fee for regular shipping (First Class U.S. mail). A fee will be charged if you request an expedited delivery. Medications requiring special packaging and refrigeration will be sent at no charge. Always indicate the address to which you would like the order shipped. Place your order at least two weeks prior to needing a refill to avoid additional cost.

Delivery Time

The average turnaround time from receipt of the prescription at the mail-order pharmacy to mailing your prescription is approximately 72 hours. If an order requires intervention (e.g., due to missing information or need for prior authorization), it may affect the average turnaround time. The average time that an order takes from you mailing the prescription and order form to receiving the medication is 14 business days.

Save time, money, and trips to the pharmacy by utilizing the home delivery pharmacy program. Mail order is ideal for maintenance medication.

Your mail-order prescription will be filled with a generic medication when available, medically appropriate, and authorized by your physician.

Filling Your Prescription

Your mail-order prescription will be filled with a general medication when available, medically appropriate, and authorized by your physician. Your physician can request that OptumRx fill your prescription with a brand-name medication by specifying "brand necessary" on the original prescription sent to the mail order pharmacy.

Refills

For refills, you will need to do one of the following approximately two weeks before your current supply will run out:

- Phone - You can order 24 hours a day by calling the toll-free number listed on the back of your ID card.
- Mail - You will need to complete the Order Form included with your medication and mail it along with appropriate copayment to the mail-order pharmacy.
- Online - You can initiate refills through myuhc.com. If you have previously filled a prescription using online mail order, you can select "manage my prescriptions" then select "refill my medication." If you have not previously used mail order pharmacy, it will ask you if you want to enroll in home delivery for that drug.

If you forget to order, you can call OptumRx to request overnight or second-day delivery for an additional cost.

If your prescription has no refills remaining, please ask your physician for a new prescription and send the new prescription to OptumRx with a completed Order Form and appropriate copayment.

Order Forms are available at myuhc.com.

Utilization Management

Managing care by managing resources

UHC has developed a utilization management program to help members obtain appropriate care, in the right setting, at the right time.

Utilization management involves evaluating the need for, and appropriateness and effectiveness of, health care services. Proposed medical care is compared to accepted standards, while variances or concerns about quality are addressed with the attending physician. Utilization management activities focus on quality health care: encouraging the use of clinical practice guidelines, health management, and wellness programs.

UHC's Case Management program works closely with members, their families, and their physicians to agree on a treatment plan and encourage quality, cost-effective care.

UHC's relationship with providers

Medical providers are independent contractors, not employees or agents of the health plan. You and your medical provider, not the health plan, decide what medical care you receive and how you receive it. UHC only determines what medical care will be paid for under your benefit plan.

Components of the Utilization Management Program

GAP Exception Authorization

Network providers request a GAP Exception when members can't receive the services they need within their network of providers. Except for Urgent/Emergent care, a prior-approved GAP Exception is required to receive in-network level benefits for each out-of-network provider and facility you use. GAP Exception requests are reviewed and a decision is made within 15 business days.

Under the Point-of-Service feature of your plan, you may see out-of-network providers without a preauthorized GAP Exception, but you will receive a lesser benefit level. Remember that some services are not covered when received from out-of-network providers, such as preventive care and organ transplants.

Preauthorization for certain services

Certain procedures must be preauthorized. Established criteria are used to determine the appropriateness of the services and the level of care to be provided. Be aware, an approved procedure does not serve as an approved GAP exception for the provider(s) or facility.

Preauthorization may be required for certain surgical and diagnostic procedures.

Concurrent review

Although physicians have the ultimate authority regarding care, length of stay and proper discharge planning, each inpatient case is reviewed against nationally accepted criteria.

Utilization management involves evaluating medical necessity, appropriateness, and effectiveness.

We offer convenient and confidential access to mental health and substance use disorder benefits by contracting with United Behavioral Health.

- United Behavioral Health is available to you 24 hours a day, seven days a week, 365 days a year.
- Call UBH toll-free at 888-533-7311.
- TTY/TDD at 800-855-9926

Mental Health/Substance Use Disorder

UHC offers convenient and confidential access to mental health and substance use disorder benefits through United Behavioral Health (UBH). UBH is the first nationally managed behavioral health organization to gain accreditation from the Joint Commission on Accreditation of Healthcare Organizations.

United Behavioral Health is available to you 24 hours a day, seven days a week. The phone lines are answered by experienced mental health care professionals who can help you access mental health or substance use disorder care.

By calling UBH at 888-533-7311 (TTY/TDD 800-855-9926), you can be referred to the appropriate qualified provider for your need.

To receive mental health and substance abuse care, you are encouraged to contact UnitedHealthcare for coordination of care and consulting. They will help refer you to an appropriate network provider.

UBH services offer you:

- Easy access to mental health and substance use disorder care – calling the toll-free number is all you have to do.
- Qualified mental health professionals who will refer you to an appropriate, qualified provider for your particular need.
- Mental health and substance use disorder services that include individual and group therapy, psychiatric evaluation, and medication management.
- An interactive website for members (liveandworkwell.com) via a link on the UHC website at myuhc.com.

Questions you may have about your mental health benefits

Q: What is the first step in getting care?

A: Call United Behavioral Health (UBH) at 888-533-7311 (TTY/TDD 800-855-9926) any time.

Q: Why is it important to arrange care through UBH?

A: It’s important that you call UBH when you need mental health or substance use disorder services because they can help you get appropriate care quickly and conveniently from a network provider. Also, your coverage requires that notification is complete in order for benefits to be paid.

Q: Can I select my own provider?

A: When you call UBH at their toll-free number, a mental health professional will assist you in selecting a network provider who is appropriate for handling your specific needs.

Q: How do I know what providers are in the network?

A: When you call UBH at their toll-free number, you are immediately connected with a mental health professional who will help you find an independent contracted provider who can best meet your needs.

Q: What if I have a mental health or substance use disorder emergency?

A: Call UBH at 888-533-7311 (TTY/TDD 800-855-9926) and a counselor will direct you toward the best care for your situation. Emergency services do not require prior notification by UBH. However, for emergency admissions, notification should occur within 24 hours of admission.

Health and Wellbeing Resources

Go to deere.com/wellbeing to access details on the programs, resources, and educational materials to support your physical and mental wellbeing.

Confidentiality/Privacy

Your health is your own private business. We can assure you that we will treat your medical records and claims payment history in a confidential manner.

The Health Insurance Portability and Accountability Act (HIPAA) allows for use and disclosure of your protected health information, without your prior written consent for the following purposes:

- Claim processing, billing, and payment.
- Performing peer review, utilization review, and medical audits.
- Administration of any programs established by us to promote quality health care and control of health care costs.

Glossary of Terms

Coinsurance

A portion of covered health care costs a member may be financially responsible for paying, usually according to a fixed percentage set by your benefit plan. Coinsurance is often applied after a deductible requirement is met.

Copayment

A cost-sharing arrangement in which a covered person pays a specific charge for a specific service (for example, $15 for a primary care physician visit, or $25 for a specialist visit).

Deductible

The amount of health care costs that a covered person may be required to pay out-of-pocket each year before the health plan will make payments for eligible benefits. This amount is calculated separately from copayments and coinsurance.

Emergency Care

The medical care necessary to respond to a condition showing itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or with respect to pregnant women, the health of the pregnant woman or her unborn child), serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Explanation of Benefits

The statement sent to covered persons by their health plan listing the services provided, amounts billed, and the plan payment made.

Generic Drug

A chemically equivalent form of a brand-name prescription drug for which the patent has expired. A generic drug is equally effective, but typically less expensive than the brand name and is sold under the common “generic” name for that drug.

Premier Network

The network of doctors, hospitals, and other health care providers contracted to provide health care services to health plan members. Providers who are not part of this network are called “out-of-network” providers.

Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP)

UHC will use MAB/MNRP to determine the benefits payable for medical services received from out-of-network providers without a preauthorized GAP Exception. UHC determines the MAB/MNRP for all covered services in advance. UHC’s MAB/MNRP determination is based on its contracted rates for network providers. You are responsible for paying any amounts in excess of the MAB/MNRP for out-of-network services.

Out-of-Pocket Maximum

Under the Premier network, this is the maximum amount you would pay through the Point-of-Service, or out-of-network option for covered services. The out-of-network deductible and coinsurance accumulate toward the Out-of-Pocket Maximum. However, expenses incurred for charges in excess of the MAB/MNRP are not included in the Out-of-Pocket Maximum. Even if you meet your annual Out-of-Pocket Maximum, you will continue to pay for any amounts in excess of the MAB/MNRP for out-of-network covered services.

Preauthorized GAP Exception

A preauthorized GAP Exception is written authorization from a network physician for medically necessary covered services, treatments, or medications from another provider. The GAP Exception must be approved by the health plan before services are provided.

Prescription Drug List (PDL)

A listing of prescription drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed care population.

Urgent Care Services

Urgent Care Services will be covered when such services are medically necessary and immediately required:

- as a result of an unforeseen illness, injury, or condition while out of the service area; or
- while in the service area, it is not reasonable given the circumstances to obtain services through your network primary care physician (must use network urgent care facility).

Utilization Management

Utilization management involves evaluating the need for, and appropriateness and effectiveness of, health care services. Proposed medical care is compared to accepted standards, while variances or concerns about quality are addressed with the attending physician. Utilization management activities focus on quality health care: encouraging use of clinical practice guidelines, health management, and wellness programs.

Frequently Asked Questions

Network Development

Q: How were the providers chosen?

A: The Premier network has been built to provide you with quality health care providers who meet our access and availability guidelines (Centers for Medicare & Medicaid Services and National Committee for Quality Assurance), quality standards, physician-to-member ratios, and terms of the network provider agreement. UHC follows federal standards (U.S. Department of Health and Human Services) to help ensure that the provider network is sufficient to meet the projected needs of the population. Please be assured that the provider network will be sufficient to provide you and your family with access to quality, cost-effective health care providers.

Provider Changes

Q: How do I get my doctor added to the provider network?

A: UHC will continually monitor the Premier panel to help ensure that we are meeting the provider access and availability standards of CMS and NCQA. While we know that the network will not have everyone's physician in it, we are happy to respond to member feedback concerning physician participation.

Q: How long before the network changes?

A: Access and availability of network providers will be evaluated continually to help ensure that we are meeting the provider access and availability standards of CMS and NCQA.

Q: What if my doctor joins a different group? How does that affect his/her network participation?

A: As physician changes occur in the community, addition to or removal from the network will be evaluated (depending on many factors, including access and availability measures, provider contractors, etc.). Always check to see if your provider's new location is considered part of the Premier Network.

Q: Do I need to call UHC and advise them I am changing my primary care physician?

A: No, this is not required.

Q: Are all of the physicians listed today taking new patients?

A: Members can expect timely access to health care from Premier network providers. Providers in the Premier network have access and availability requirements, which they must meet. UHC is working with physicians to encourage them to accept new patients and to be available to see members. UHC routinely reviews access and availability to help ensure that providers are available and receiving new patients. In the instance when you request a physician who is not available at the date/time you are requesting, you may be directed to see a network physician who is in the same office as the physician you are requesting to see.

If you have questions regarding whether a network provider is taking new patients, please check for providers online at myuhc.com or contact UHC at the member number on your medical ID card.

Q: How do I transfer my medical records?

A: Members transitioning their medical care to a Premier network provider may be asked to obtain medical records from the previous provider. To do this, simply contact the physician you are transferring care from, and he or she will explain the process for obtaining your records. Patient requests to release medical records will normally require you to sign a release form, which is supplied by your physician.

Once a release is signed, you and your physician can discuss whether records will be mailed to the new provider or given directly to you. If you require assistance, please contact Customer Service.

Q: How do I have a prescription refilled if my physician is no longer in the network?

A: If your prescription has refills remaining, you may continue to fill those prescriptions. If your refills are nearly gone and you plan a change to a network physician, you should see your new network provider and any new prescriptions will come from that provider.

GAP Exceptions

Q: What happens if I need services that are not provided by a network doctor or hospital?

A: The Premier network has been developed to provide you with access to most of the services that you will need. If your physician determines that you need care that is not available within the Premier network, he or she will request a preauthorized GAP Exception from UHC.

Coverage (payment) authorization must be approved before out-of-network services are received, except for Emergency and Urgent Care Services.

Q: What if my doctor sends me to an out-of-network hospital or facility for a procedure or appointment?

A: If the admission is not an emergency, services will be payable under your Point-of-Service (POS) benefits. You are responsible to confirm whether a provider or facility is a network provider. Please check for providers online at myuhc.com, or contact UHC at the member number on the back of your medical ID card.

Q: What happens if I go to an out-of-network laboratory or radiology provider, or if my network provider sends me there?

A: Covered services will be payable under your Point-of-Service (POS) benefits. You are responsible for confirming whether your provider is a network provider. Please refer to your Premier Provider search on myuhc.com or contact UHC at the member number on the back of your ID card.

Q: If I am a patient at a network hospital and my network doctor calls in an out-of-network doctor, what are my benefits?

A: Covered services will be considered at your network level of benefits.

Q: I have a child who is a college student and is receiving care out of the area. How will this be covered?

A: If your college student resides within the Premier service area, he or she must use network providers to receive the network level of benefits. If your college student resides outside the Premier service area, he or she will be covered for emergency care services. If he or she has a chronic medical condition, please contact the John Deere Benefits Center at 1-844-689-7833 regarding coverage available outside the Premier service area.

Q: I currently travel to Florida for the winter; if I need medical care, how will it be covered?

A: You will be covered for Emergency and Urgent Care Services. If you have a chronic medical condition, please contact the John Deere Benefits Center at 1-844-689-7833 regarding coverage available outside the Premier service area.

Point-of-Service/Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP)

Q: How does Point-of-Service (POS) work? What's covered and what isn't?

A: For covered services rendered by an out-of-network provider, payment will be based on 80% of the MAB/MNRP with 20% coinsurance paid by the member after satisfying a $250/individual or $500/family deductible per calendar year. Your Point-of-Service (POS) benefit does not cover preventive care, durable medical equipment, prosthetic devices, home health care, organ transplants, or mental health/substance use disorder services. Your POS benefit also does not cover the amount charged above MAB/MNRP.

Q: What is Maximum Allowable Benefit (MAB) or Maximum Non-Network Reimbursement Program (MNRP)?

A: The MAB/MNRP is the amount UHC will use to determine benefits available for medical services you receive from out-of-network providers without a preauthorized GAP Exception. The UHC MAB/MNRP determination is based on its contracted rates for network providers.

Q: What happens if I go to an out-of-network pharmacy?

A: There is no change to the current reimbursement method for using an out-of-network pharmacy. The plan will reimburse payment to you at the contracted rate for a network pharmacy, less the applicable copayment.

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This information is intended solely for members of benefit plans administered by UnitedHealthcare.

Assurance of Non-Discrimination: No person on the grounds of race, color, national origin, sex, age, religion, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by UnitedHealthcare.