BAYCARE HEALTH SYSTEMS, LLC
GREEN BAY WI

Health Benefit Summary Plan Description
7670-00-411979

Revised 01-01-2026

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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BAYCARE HEALTH SYSTEMS, LLC

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the BAYCARE HEALTH SYSTEMS, LLC Health Benefit Plan (the "Plan"). You are a valued Employee of BAYCARE HEALTH SYSTEMS, LLC, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

BAYCARE HEALTH SYSTEMS, LLC is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and CVS Caremark for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document. It is being furnished to You in accordance with ERISA.

This document became effective on January 1, 2016.

PLAN INFORMATION

Plan Name	BAYCARE HEALTH SYSTEMS, LLC GROUP BENEFIT PLAN
Name And Address Of Employer	BAYCARE HEALTH SYSTEMS, LLC 1035 KEPLER DR GREEN BAY WI 54311
Name, Address, And Phone Number Of Plan Administrator	BAYCARE HEALTH SYSTEMS, LLC 1035 KEPLER DR GREEN BAY WI 54311 920-490-9046
Named Fiduciary	BAYCARE HEALTH SYSTEMS, LLC
Employer Identification Number Assigned By The IRS	39-1850939
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	BAYCARE HEALTH SYSTEMS, LLC 1035 KEPLER DR GREEN BAY WI 54311 Service of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31

ERISA And Other Federal Compliance

It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and, further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS – Blue Plan

Benefit Plan(s) 001 – Blue Plan

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization is recommended prior to obtaining services. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	Tier 1	Tier 2	Tier 3
Annual Deductible Per Calendar Year:			
• Per Person	$1,750	$2,750	$5,000
• Per Family	$3,500	$5,500	$10,000
– Individual Embedded Deductible	$1,750	$2,750	$5,000
Note: Embedded Deductible Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than Their Embedded Individual Deductible Amount.			
Plan Participation Rate, Unless Otherwise Stated Below:			
• Paid By Plan After Satisfaction Of Deductible	90%	70%	50%
Annual Out-Of-Pocket Maximum:			
Note: Tier 1 And Tier 2 Represents The Total Paid For Deductible, Coinsurance And Co-pays. Pharmacy Expenses Track To The Tier 1 Out-of-Pocket Limit.			
Tier 3 Represents The Total Paid For Coinsurance Only. The Deductible Is Not Included In The Tier 3 Out-of-Pocket Limit.			
• Per Person	$3,500	$5,500	$17,500
• Per Family	$7,000	$11,000	$22,500

	Tier 1	Tier 2	Tier 3
Acupuncture Treatment: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 20 Visits 90%	No Benefit	No Benefit
Additional Safety (Auto Accident Claims Involving Not Wearing A Seat Belt Or Wearing A Helmet Or Protective Headgear): • Maximum Penalty Per Covered Person Per Incident • Paid By Plan After Deductible	 $5,000 90%	 $5,000 70%	 $5,000 50%
Ambulance Transportation: **Ground:** • Paid By Plan After Tier 1 Deductible ***Note: Unsuccessful Out Of Network Ground Ambulance Negotiated Amounts Will Only Be Subject To Deductible And Out Of Pocket Maximums.*** **Air:** • Paid By Plan After Tier 1 Deductible	 90% 90%	 90% 90%	 90% 90%
Breast Pumps: • Paid By Plan After Deductible	 100% (Deductible Waived)	 100% (Deductible Waived)	 50%
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: **For Men:** • Paid By Plan After Deductible **For Women:** • Paid By Plan After Deductible	 90% 100% (Deductible Waived)	 70% 100% (Deductible Waived)	 No Benefit No Benefit
Durable Medical Equipment: • Paid By Plan After Deductible	 90%	 70%	 50%
Emergency Services / Treatment: **Emergency Room / Emergency Physicians:** • Co-pay Per Day • Paid By Plan After Tier 1 Deductible ***Note: Co-pay Waived If Admitted As Inpatient Within 24 Hours.***	 $100 90%	 $100 90%	 $100 90%

	Tier 1	Tier 2	Tier 3
Urgent Care: • Co-pay Per Visit • Paid By Plan After Deductible ***Note: For Tier 2 And Tier 3, Benefits Are Not Payable Unless The Provider Is Located Outside Of The Network Tier 1 Service Area, As Defined By The Plan Administrator.***	 $30 90% (Deductible Waived)	 $30 90% (Deductible Waived)	 $30 90% (Deductible Waived)
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 90%	 30 Days 70%	 50%
Gender Dysphoria **Office Visit:** • Co-pay Per Visit • Paid By Plan After Deductible **All Other Services If Billed With An Office Visit:** • Paid By Plan After Deductible **All Other Services If Billed Without An Office Visit:** • Paid By Plan After Deductible **Travel And Lodging:** • Maximum Benefit Per Calendar Year • Paid By Plan	 $30 90% (Deductible Waived) 90% (Deductible Waived) 90% $2,000 100% (Deductible Waived)	 $60 70% (Deductible Waived) 70% (Deductible Waived) 70% 100% (Deductible Waived)	 Not Applicable 50% 50% 50% No Benefit
Hearing Services: **Exams / Tests:** • Paid By Plan After Deductible **Hearing Aids:** • Paid By Plan After Deductible **Implantable Hearing Devices:** • Paid By Plan After Deductible	 90% 90% 90%	No Benefit	No Benefit

	Tier 1	Tier 2	Tier 3
Home Health Care Benefits:			
• Maximum Visits Per Calendar Year		40 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.			
Hospice Care Benefits:			
Hospice Services:			
• Paid By Plan After Deductible	90%	70%	50%
Bereavement Counseling:			
• Maximum Visits Per Calendar Year		12 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Hospital Services:			
Pre-Admission Testing:			
• Paid By Plan After Deductible	90%	70%	50%
Inpatient Services/Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Imaging Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Lab Charges:			
• Paid By Plan After Deductible	90% (Deductible Waived)	70%	50%
Outpatient Surgery / Surgeon Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient X-Ray Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Physician Clinic Visits In An Outpatient Hospital Setting – Facility Claim:			
• Paid By Plan After Deductible	90%	70%	50%
Physician Clinic Visits In An Outpatient Hospital Setting – Physician Claim:			
• Co-pay Per Visit	$30	$60	Not Applicable
• Paid By Plan After Deductible	90% (Deductible Waived)	70% (Deductible Waived)	50%

	Tier 1	Tier 2	Tier 3
Implanted Electrical Spinal Cord Stimulators: • Paid By Plan After Deductible	90%	No Benefit	No Benefit
Insulin Infusion Pump: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible ***Note: Maximum Benefit Does Not Include Disposable Pumps.***	90%	1 Pump 70%	50%
Manipulations: • Maximum Benefit Per Calendar Year • Maximum Benefit Per Day • Paid By Plan After Deductible	90%	$1,000 1 Visit 70%	50%
Maternity: **Routine Prenatal Services:** • Paid By Plan After Deductible **Non-Routine Prenatal Services, Delivery And Postnatal Care:** • Paid By Plan After Deductible	100% (Deductible Waived) 90%	100% (Deductible Waived) 70%	50% 50%
Mental Health And Substance Use Disorder Benefits: **Inpatient Services/Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:** • Paid By Plan After Deductible **Residential Treatment:** • Paid By Plan After Deductible **Outpatient Or Partial Hospitalization Services:** • Paid By Plan After Deductible **Office Visit:** • Co-pay Per Visit • Paid By Plan After Deductible	90% 90% 90% $30 90% (Deductible Waived)	70% 70% 70% $60 70% (Deductible Waived)	50% 50% 50% Not Applicable 50%

	Tier 1	Tier 2	Tier 3
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility** **Office Visit:** • Co-pay Per Visit • Paid By Plan After Deductible **The Co-pays Will Not Apply To:** ➢ **Independent Lab** ➢ **Services Billed By Radiologist Or Pathologist Including Independent Radiology Facility (Freestanding Radiology Facility)**	 $30 90% (Deductible Waived)	 $60 70% (Deductible Waived)	 Not Applicable 50%
Physician Office Services: • Paid By Plan After Deductible **Diagnostic Lab:** • Paid By Plan After Deductible	 90% 90% (Deductible Waived)	 70% 70% (Deductible Waived)	 50% 50% (Deductible Waived)
Prescription For Health Benefit: • Maximum Benefit Per Calendar Year Regardless Of Diagnosis • Paid By Plan After Deductible • Dependent Children Are Not Eligible	 $1,000 90% (Deductible Waived)	 No Benefit	 No Benefit
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan After Deductible **Preventive / Routine Autism Screening:** To Age 21 • Paid By Plan After Deductible	 100% (Deductible Waived) 100% (Deductible Waived)	 70% 100% (Deductible Waived)	 No Benefit No Benefit

	Tier 1	Tier 2	Tier 3
Immunizations: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Foreign Travel Immunizations: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Breast Cancer Screenings And Exams: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Pelvic Exams And Pap Tests: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine PSA Test And Prostate Exams: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: • Maximum Benefit Per Calendar Year Regardless Of Diagnosis • Paid By Plan After Deductible ***Note: One Colonoscopy Is Covered Per Year Regardless Of Diagnosis.***	1 Exam 100% (Deductible Waived)	No Benefit	No Benefit

	Tier 1	Tier 2	Tier 3
Preventive / Routine Hearing Exams: • Paid By Plan After Deductible	90%	70%	No Benefit
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Treatment For Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan After Deductible ***These Services May Also Apply To Men.**	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Prosthetics: • Maximum Benefit Per Each Type of Prosthetic Due To Medical Necessity • Paid By Plan After Deductible	1 Purchase 90%	70%	50%
Sterilizations: **For Men:** • Paid By Plan After Deductible	90%	70%	50%
For Women: • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	50%
Telehealth: • Co-pay Per Visit • Paid By Plan After Deductible	$30 90% (Deductible Waived)	$60 70% (Deductible Waived)	Not Applicable 50%
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	90%	70%	50%

	Tier 1	Tier 2	Tier 3
Therapy Services: **Occupational Outpatient Hospital / Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 90%	 20 Visits 70%	 50%
Physical Outpatient Hospital / Office Therapy: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible **Physical Therapy Provided By A Licensed Athletic Trainer (LAT) Outpatient Hospital / Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible **Respiratory Outpatient Hospital / Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible **Speech Outpatient Hospital / Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: Treatment Of Cerebral Vascular Accidents (CVA) Burns, Fractures And Other Conditions For Which You Are Hospitalized Or Had Surgery, Are Payable As Any Other Illness Or Injury. Such Treatment Is Not Subject To The Limits Shown Above For Physical, Speech Or Occupational Therapy. However, They Are Subject To Medical Necessity. Medical Records Will Be Requested From The Provider Of Services To Determine Medical Necessity. If It Is Determined That Charges Are Not Medically Necessary, Charges Will Be Denied And Will Be The Patient's Responsibility.***	 90% 40 Visits 90% 90% 90% 90%	 15 Visits 70% No Benefit 20 Visits 70% 20 Visits 70%	 50% No Benefit 50% 50% 50%
Threaded Carpal Tunnel: • Paid By Plan After Deductible	90%	No Benefit	No Benefit
Threaded Trigger Finger: • Paid By Plan After Deductible	90%	No Benefit	No Benefit
Vision Care Benefits: **Eye Exam:** • Maximum Exams Per Calendar Year • Maximum Exams Every Other Calendar Year • Paid By Plan After Deductible	 1 Exam Not Applicable 100% (Deductible Waived)	 Not Applicable 1 Exam 70%	 No Benefit

	Tier 1	Tier 2	Tier 3
Refraction:			
• Maximum Exams Per Calendar Year	1 Exam	Not Applicable	
• Maximum Exams Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Optomap Retinal Imaging:			
• Maximum Benefit Every Calendar Year	1 Exam	Not Applicable	Not Applicable
• Maximum Benefit Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	90%	70%	No Benefit
Vision Therapy And Orthoptics:			
• Maximum Benefit Every Calendar Year		5 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:			
• Maximum Benefit Per Calendar Year		$500	
• Paid By Plan After Deductible	90%	70%	50%
All Other Covered Expenses:			
• Paid By Plan After Deductible	90%	70%	50%

MEDICAL SCHEDULE OF BENEFITS – Silver Plan

Benefit Plan(s) 003, 004 – Silver Plan

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits listed in this Schedule of Benefits are subject to all provisions of the Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization is recommended prior to obtaining services. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	Tier 1	Tier 2	Tier 3
Annual Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.*** • Per Person • Per Family ***Note: If Family Coverage Is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.***	 $2,000 $4,000	 $3,500 $7,000	 $6,000 $12,000
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	90%	70%	50%
Annual Out-Of-Pocket Maximum: ***Note: Medical, And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Per Person • Per Family ***Note: If Family Coverage Is Elected, The Full Family Out-Of-Pocket Maximum Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.***	 $3,000 $6,000	 $7,000 $14,000	 $21,000 $27,000
Acupuncture Treatment: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 20 Visits 90%	No Benefit	No Benefit

	Tier 1	Tier 2	Tier 3
Additional Safety (Auto Accident Claims Involving Not Wearing A Seat Belt Or Wearing A Helmet Or Protective Headgear):			
• Maximum Penalty Per Covered Person Per Incident	$5,000	$5,000	$5,000
• Paid By Plan After Deductible	90%	70%	50%
Ambulance Transportation:			
Ground:			
• Paid By Plan After Tier 1 Deductible	90%	90%	90%
Note: Unsuccessful Out Of Network Ground Ambulance Negotiated Amounts Will Only Be Subject To Deductible And Out Of Pocket Maximums.			
Air:			
• Paid By Plan After Tier 1 Deductible	90%	90%	90%
Breast Pumps:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	50%
Contraceptive Methods Approved By The FDA And Contraceptive Counseling:			
For Men:			
• Paid By Plan After Deductible	90%	70%	No Benefit
For Women:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Durable Medical Equipment:			
• Paid By Plan After Deductible	90%	70%	50%
Emergency Services / Treatment:			
Emergency Room / Emergency Physicians:			
• Paid By Plan After Tier 1 Deductible	90%	90%	90%
Note: Co-pay Waived If Admitted As Inpatient Within 24 Hours.			
Urgent Care:		No Benefit	
• Paid By Plan After Deductible	90%		
Note: For Tier 2 And Tier 3, Benefits Are Not Payable Unless The Provider Is Located Outside Of The Network Tier 1 Service Area, As Defined By The Plan Administrator.			

	Tier 1	Tier 2	Tier 3
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			
• Maximum Days Per Calendar Year		30 Days	
• Paid By Plan After Deductible	90%	70%	50%
Gender Dysphoria:			
• Paid By Plan After Deductible	90%	70%	50%
Travel And Lodging:			No Benefit
• Maximum Benefit Per Calendar Year	$2,000		
• Paid By Plan After Deductible	100%	100%	
Hearing Services:		No Benefit	No Benefit
Exams / Tests:			
• Paid By Plan After Deductible	90%		
Hearing Aids:			
• Paid By Plan After Deductible	90%		
Implantable Hearing Devices:			
• Paid By Plan After Deductible	90%		
Home Health Care Benefits:			
• Maximum Visits Per Calendar Year		40 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.			
Hospice Care Benefits:			
Hospice Services:			
• Paid By Plan After Deductible	90%	70%	50%
Bereavement Counseling:			
• Maximum Visits Per Calendar Year		12 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Hospital Services:			
Pre-Admission Testing:			
• Paid By Plan After Deductible	90%	70%	50%
Inpatient Services/Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Imaging Charges:			
• Paid By Plan After Deductible	90%	70%	50%

	Tier 1	Tier 2	Tier 3
Outpatient Lab And X-Ray Charges: • Paid By Plan After Deductible	90%	70%	50%
Outpatient Surgery / Surgeon Charges: • Paid By Plan After Deductible	90%	70%	50%
Physician Clinic Visits In An Outpatient Hospital Setting: • Paid By Plan After Deductible	90%	70%	50%
Implanted Electrical Spinal Cord Stimulators: • Paid By Plan After Deductible	90%	No Benefit	No Benefit
Insulin Infusion Pump: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible ***Note: Maximum Benefit Does Not Include Disposable Pumps.***	90%	1 Pump 70%	50%
Manipulations: • Maximum Benefit Per Calendar Year • Maximum Benefit Per Day • Paid By Plan After Deductible	90%	$1,000 1 Visit 70%	50%
Maternity: **Routine Prenatal Services:** • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	50%
Non-Routine Prenatal Services, Delivery And Postnatal Care: • Paid By Plan After Deductible	90%	70%	50%
Mental Health And Substance Use Disorder Benefits: • Paid By Plan After Deductible	90%	70%	50%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility Except For Physician Clinic Visits In An Outpatient Hospital Setting** **Office Visit:** • Paid By Plan After Deductible	90%	70%	50%
Physician Office Services: • Paid By Plan After Deductible	90%	70%	50%

	Tier 1	Tier 2	Tier 3
Prescription For Health Benefit: • Maximum Benefit Per Calendar Year Regardless Of Diagnosis • Paid By Plan After Deductible • Dependent Children Are Not Eligible	$1,000 90%	No Benefit	No Benefit
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			
Preventive / Routine Physical Exams At Appropriate Ages: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Autism Screening: To Age 21 • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Immunizations: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Foreign Travel Immunizations: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Breast Cancer Screenings And Exams: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Pelvic Exams And Pap Tests: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine PSA Test And Prostate Exams: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit

	Tier 1	Tier 2	Tier 3
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:			
• Maximum Benefit Per Calendar Year Regardless Of Diagnosis	1 Exam		No Benefit
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	
Note: One Colonoscopy Is Covered Per Year Regardless Of Diagnosis.			
Preventive / Routine Hearing Exams:			
• Paid By Plan After Deductible	90%	70%	No Benefit
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Treatment For Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
***These Services May Also Apply To Men.**			

	Tier 1	Tier 2	Tier 3
Prosthetics:			
• Maximum Benefit Per Each Type of Prosthetic Due To Medical Necessity		1 Purchase	
• Paid By Plan After Deductible	90%	70%	50%
Sterilizations:			
For Men:			
• Paid By Plan After Deductible	90%	70%	50%
For Women:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	50%
Temporomandibular Joint Disorder Benefits:			
• Paid By Plan After Deductible	90%	70%	50%
Therapy Services:			
Occupational Outpatient Hospital / Office Therapy:			
• Maximum Visits Per Calendar Year		20 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Physical Outpatient Hospital / Office Therapy:			
• Maximum Visits Per Calendar Year		15 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Physical Therapy Provided By A Licensed Athletic Trainer (LAT) Outpatient Hospital / Office Therapy:			
• Maximum Visits Per Calendar Year	40 Visits	No Benefit	No Benefit
• Paid By Plan After Deductible	90%		
Respiratory Outpatient Hospital / Office Therapy:			
• Maximum Visits Per Calendar Year		20 Visits	
• Paid By Plan After Deductible	90%	70%	50%

	Tier 1	Tier 2	Tier 3
Speech Outpatient Hospital / Office Therapy:			
• Maximum Visits Per Calendar Year		20 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Note: Treatment Of Cerebral Vascular Accidents (CVA) Burns, Fractures And Other Conditions For Which You Are Hospitalized Or Had Surgery, Are Payable As Any Other Illness Or Injury. Such Treatment Is Not Subject To The Limits Shown Above For Physical, Speech Or Occupational Therapy. However, They Are Subject To Medical Necessity. Medical Records Will Be Requested From The Provider Of Services To Determine Medical Necessity. If It Is Determined That Charges Are Not Medically Necessary, Charges Will Be Denied And Will Be The Patient's Responsibility.			
Threaded Carpal Tunnel:			
• Paid By Plan After Deductible	90%	No Benefit	No Benefit
Threaded Trigger Finger:			
• Paid By Plan After Deductible	90%	No Benefit	No Benefit
Vision Care Benefits:			
Eye Exam:			
• Maximum Exams Per Calendar Year	1 Exam	Not Applicable	
• Maximum Exams Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Refraction:			
• Maximum Exams Per Calendar Year	1 Exam	Not Applicable	
• Maximum Exams Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Optomap Retinal Imaging:			
• Maximum Benefit Every Calendar Year	1 Exam	Not Applicable	Not Applicable
• Maximum Benefit Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	90%	70%	No Benefit
Vision Therapy And Orthoptics:			
• Maximum Benefit Every Calendar Year		5 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:			
• Maximum Benefit Per Calendar Year		$500	
• Paid By Plan After Deductible	90%	70%	50%
All Other Covered Expenses:			
• Paid By Plan After Deductible	90%	70%	50%

MEDICAL SCHEDULE OF BENEFITS – Black Plan

Benefit Plan(s) 005, 006 – Black Plan

This Plan has the required elements for You to be able to contribute to a tax-advantaged Health Savings Account (HSA).

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Copays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	TIER 1	TIER 2	TIER 3
Annual Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.*** • Single Coverage • Family Coverage – Individual Embedded Deductible ***Note: Embedded Deductible Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than Their Embedded Individual Deductible Amount.***	 $5,000 $10,000 $5,000	 $6,000 $12,000 $6,000	 $7,000 $14,000 $7,000
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	90%	70%	50%

	TIER 1	TIER 2	TIER 3
Annual Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Single Coverage • Family Coverage – Individual Embedded Out-Of-Pocket Maximum ***Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than Their Embedded Individual Out-Of-Pocket Maximum Amount.***	 $6,000 $12,000 $6,000	 $8,000 $16,000 $8,000	 $21,000 $28,000 $21,000
Acupuncture Treatment: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 20 Visits 90%	No Benefit	No Benefit
Additional Safety (Auto Accident Claims Involving Not Wearing A Seat Belt Or Wearing A Helmet Or Protective Headgear): • Maximum Penalty Per Covered Person Per Incident • Paid By Plan After Deductible	 $5,000 90%	 $5,000 70%	 $5,000 50%
Ambulance Transportation: **Ground:** • Paid By Plan After Tier 1 Deductible ***Note: Unsuccessful Out Of Network Ground Ambulance Negotiated Amounts Will Only Be Subject To Deductible And Out Of Pocket Maximums.*** **Air:** • Paid By Plan After Tier 1 Deductible	 90% 90%	 90% 90%	 90% 90%
Breast Pumps: • Paid By Plan After Deductible	 100% (Deductible Waived)	 100% (Deductible Waived)	 50%
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: **For Men:** • Paid By Plan After Deductible **For Women:** • Paid By Plan	 90% 100% (Deductible Waived)	 70% 100% (Deductible Waived)	No Benefit

	TIER 1	TIER 2	TIER 3
Durable Medical Equipment: • Paid By Plan After Deductible	90%	70%	50%
Emergency Services / Treatment: **Urgent Care:** • Paid By Plan After Deductible **Emergency Room / Emergency Physicians:** • Paid By Plan After Tier 1 Deductible ***Note: For Tier 2 And Tier 3, Benefits Are Not Payable Unless The Provider Is Located Outside Of The Network Tier 1 Service Area, As Defined By The Plan Administrator.***	 90% 90%	 No Benefit 90%	 90%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 90%	 30 Days 70%	 50%
Gender Dysphoria: • Paid By Plan After Deductible **Travel And Lodging:** • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 90% $2,000 100%	 70% 100%	 50% No Benefit
Hearing Services: **Exams / Tests:** • Paid By Plan After Deductible **Hearing Aids:** • Paid By Plan After Deductible **Implantable Hearing Devices:** • Paid By Plan After Deductible	 90% 90% 90%	No Benefit	No Benefit
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	 90%	 40 Visits 70%	 50%
Hospice Care Benefits: **Hospice Services:** • Paid By Plan After Deductible **Bereavement Counseling:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 90%	 70% 12 Visits 70%	 50% 50%

	TIER 1	TIER 2	TIER 3
Hospital Services:			
Pre-Admission Testing:			
• Paid By Plan After Deductible	90%	70%	50%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Advanced Imaging Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Lab And X-Ray Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Surgery / Surgeon Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Physician Clinic Visits In An Outpatient Hospital Setting:			
• Paid By Plan After Deductible	90%	70%	50%
Implanted Electrical Spinal Cord Stimulators:			
• Paid By Plan After Deductible	90%	No Benefit	No Benefit
Insulin Infusion Pump:			
• Maximum Benefit Per Calendar Year		1 Pump	
• Paid By Plan After Deductible	90%	70%	50%
Note: Maximum Benefit Does Not Include Disposable Pumps.			
Manipulations:			
• Maximum Benefit Per Calendar Year		$1,000	
• Maximum Benefit Per Day		1 Visit	
• Paid By Plan After Deductible	90%	70%	50%
Maternity:			
Routine Prenatal Services:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	50%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:			
• Paid By Plan After Deductible	90%	70%	50%

	TIER 1	TIER 2	TIER 3
Mental Health And Substance Use Disorder Benefits:			
Inpatient Services / Physician Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Residential Treatment:			
• Paid By Plan After Deductible	90%	70%	50%
Outpatient Or Partial Hospitalization Services And Physician Charges:			
• Paid By Plan After Deductible	90%	70%	50%
Office Visit:			
• Copay Per Visit	Not Applicable	$30	Not Applicable
• Paid By Plan After Deductible	90%	70%	50%
Tobacco Addiction:			
• Paid By Plan After Deductible	90%	70%	50%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting:			
This Section Does Not Apply To: ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility**			
Office Visit:			
• Paid By Plan After Deductible	90%	70%	50%
Physician Office Services:			
• Paid By Plan After Deductible	90%	70%	50%
Prescription For Health Benefit:			
• Maximum Benefit Per Calendar Year Regardless Of Diagnosis	$1,000	No Benefit	No Benefit
• Paid By Plan After Deductible	90%		
• Dependent Children Are Not Eligible			
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			
Preventive / Routine Physical Exams At Appropriate Ages:			
• Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Autism Screening: To Age 21			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit

	TIER 1	TIER 2	TIER 3
Immunizations: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Foreign Travel Immunizations: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Breast Cancer Screenings And Exams: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Pelvic Exams And Pap Tests: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	
Preventive / Routine PSA Test And Prostate Exams: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: • Maximum Exams Per Calendar Year • Paid By Plan After Deductible	1 Exam 100% (Deductible Waived)		No Benefit
Preventive / Routine Hearing Exams: • Paid By Plan After Deductible	90%	70%	No Benefit
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Paid By Plan After Deductible	100% (Deductible Waived)	70%	No Benefit

	TIER 1	TIER 2	TIER 3
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Prosthetics: • Maximum Benefit Per Each Type of Prosthetic Due To Medical Necessity • Paid By Plan After Deductible	90%	1 Purchase 70%	50%
Sterilizations: **For Men:** • Paid By Plan After Deductible **For Women:** • Paid By Plan After Deductible	90% 100% (Deductible Waived)	70% 100% (Deductible Waived)	50% 50%
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	90%	70%	50%
Therapy Services: **Occupational Outpatient Hospital And Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible **Physical Outpatient Hospital And Office Therapy:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible • Paid By Plan After Deductible	90% 90% 100% (Deductible Waived)	20 Visits 70% 15 Visits 70% 70%	50% 50% No Benefit
Physical Therapy Provided By A Licensed Athletic Trainer (LAT) Outpatient Hospital / Office Therapy: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	40 Visits 90%	No Benefit	No Benefit

	TIER 1	TIER 2	TIER 3
Respiratory Therapy:			
• Maximum Visits Per Calendar Year		20 Visits	
Speech Outpatient Hospital / Office Therapy:			
• Maximum Visits Per Calendar Year		20 Visits	
• Paid By Plan After Deductible	90%	70%	50%
Note: Treatment Of Cerebral Vascular Accidents (CVA) Burns, Fractures And Other Conditions For Which You Are Hospitalized Or Had Surgery, Are Payable As Any Other Illness Or Injury. Such Treatment Is Not Subject To The Limits Shown Above For Physical, Speech Or Occupational Therapy. However, They Are Subject To Medical Necessity. Medical Records Will Be Requested From The Provider Of Services To Determine Medical Necessity. If It Is Determined That Charges Are Not Medically Necessary, Charges Will Be Denied And Will Be The Patient's Responsibility.			
Threaded Carpal Tunnel:			
• Paid By Plan After Deductible	90%	No Benefit	No Benefit
Threaded Trigger Finger:			
• Paid By Plan After Deductible	90%	No Benefit	No Benefit
Vision Care Benefits:			
Eye Exam:			
• Maximum Exams Per Calendar Year	1 Exam	Not Applicable	
• Maximum Exams Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%	50%
Refraction:			
• Maximum Exams Per Calendar Year	1 Exam	Not Applicable	
• Maximum Exams Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%	50%
Optomap Retinal Imaging:			
• Maximum Benefit Every Calendar Year	1 Exam	Not Applicable	Not Applicable
• Maximum Benefit Every Other Calendar Year	Not Applicable	1 Exam	
• Paid By Plan After Deductible	90%	70%	No Benefit
Vision Therapy And Orthoptics:			
• Maximum Benefit Every Calendar Year		5 Visits	
• Paid By Plan After Deductible	90%	70%	50%

	TIER 1	TIER 2	TIER 3
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:			
• Maximum Benefit Per Calendar Year		$500	
• Paid By Plan After Deductible	90%	70%	50%
All Other Covered Expenses:			
• Paid By Plan After Deductible	90%	70%	50%

TRANSPLANT SCHEDULE OF BENEFITS – Blue Plan The program for Transplant Services at Designated Transplant Facilities is: Optum Benefit Plan(s) 001 – Blue Plan			
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	100% (Deductible Waived)		
	Tier 1	**Tier 2**	**Tier 3**
Transplant Services At A Non-Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	90%	90%	50%

TRANSPLANT SCHEDULE OF BENEFITS – Silver Plan The program for Transplant Services at Designated Transplant Facilities is: Optum Benefit Plan(s) 003, 004 – Silver Plan			
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	100%		
	Tier 1	**Tier 2**	**Tier 3**
Transplant Services At A Non-Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	90%	90%	50%

TRANSPLANT SCHEDULE OF BENEFITS – Black Plan The program for Transplant Services at Designated Transplant Facilities is: Optum Benefit Plan(s) 005, 006 – Black Plan			
Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible	100%		
	TIER 1	**TIER 2**	**TIER 3**
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible	90%	90%	50%

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – Blue Plan
CVS Caremark

Benefit Plan 001 – Blue Plan

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact CVS Caremark at 866-818-6911 or your employer with any questions related to this coverage or services.

Prescription Drug Plan Out-of-Pocket Maximum, per Calendar Year	**Participating Pharmacy**
• Per Person	$3,500
• Per Family *Embedded Out-of-Pocket Maximum*: If family coverage is elected, all Covered Persons contribute toward the family Out-of-Pocket maximum, but no individual will pay more than their own individual Out-of-Pocket Maximum	$7,000
Medical and Pharmacy expenses are subject to the same medical Out-of-Pocket Maximum	

Covered Prescription Drug Expenses	**Participating Pharmacy**
Retail up to a 31-Day Supply (if purchased from a participating retail pharmacy)	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	30% Coinsurance with a minimum of $10
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	30% Coinsurance with a minimum of $30
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred medications	30% Coinsurance with a minimum of $60

Retail up a 93-Day Supply (if purchased from a participating retail pharmacy)	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	30% Coinsurance with a minimum of $30
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	30% Coinsurance with a minimum of $90
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred medications	30% Coinsurance with a minimum of $180

CVS Caremark Mail Order up to a 93-Day Supply	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	$50
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	$150
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name medications and non-preferred medications	$250

Specialty Drugs up to a 31-Day Supply	
CVS Caremark Specialty Pharmacy must be used to fill specialty medications • **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications • **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications • **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred Note: Prior Authorization on Specialty and other select medications may apply. For further information, call CVS Caremark at 866-818-6911.	10% Coinsurance with a maximum of $150 10% Coinsurance with a maximum of $150 10% Coinsurance with a maximum of $150

Specific Pharmacy Benefit Limitations	
Nicotine Cessation – Maximum Benefit Per Calendar Year by Participating Retail Pharmacy	Limit of 168-day-supply of each product in one year of treatment $0 Copayment
Prescription Drugs dispensed by non-Participating Pharmacy	Use of a non-Participating Pharmacy requires payment for the Prescription upfront. The Covered Person may then submit a claim reimbursement form with a receipt to CVS Caremark. Reimbursement for covered Prescription Drugs will be based on the lowest contracted amount of a Participating Pharmacy minus any applicable cost share shown on this Schedule.

Note:

- When the Covered Person purchases a brand-name product that has a generic equivalent, he or she must pay the applicable brand-name Copayment plus the difference in cost between the generic Drug and the brand-name Drug when the medical professional has not specified a brand-name Drug or has not indicated that the brand-name Drug is Medically Necessary.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – Silver Plan
CVS Caremark

Benefit Plan(s) 003, 004 – Silver Plan
Qualified High Deductible Plan

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact CVS Caremark at 866-818-6911 or your employer with any questions related to this coverage or services.

Prescription Drug Plan Deductible, per Calendar Year	Participating Pharmacy
• Per Person • Per Family – *Non-embedded Deductible:* If family coverage is elected, the full family Deductible amount must be met before the Plan begins paying Covered Expenses Medical and Pharmacy expenses are subject to the same Deductible	$2,000 $4,000

Out-of-Pocket Maximum, per Calendar Year	Participating Pharmacy
• **Per Person** • **Per Family** – *Non-embedded Out-of-Pocket Maximum:* If family coverage is elected, the full family Maximum Out-of-Pocket amount must be met before the Plan begins paying Covered Expenses in full Medical and Pharmacy expenses are subject to the same Out-of-Pocket Maximum	$3,000 $6,000

Covered Prescription Drug Expenses	Participating Pharmacy
Retail up to a 31-Day Supply (if purchased from a participating retail pharmacy)	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred medications	Deductible, then 10% Coinsurance

Retail up a 93-Day Supply (if purchased from a participating retail pharmacy)	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred medications	Deductible, then 10% Coinsurance

CVS Caremark Mail Order up to a 93-Day Supply	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name medications and non-preferred medications	Deductible, then 10% Coinsurance
Specialty Drugs up to a 31-Day Supply	
CVS Caremark Specialty Pharmacy must be used to fill specialty medications	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred	Deductible, then 10% Coinsurance
Note: Prior Authorization on Specialty and other select medications may apply. For further information, call CVS Caremark at 866-818-6911.	

Specific Pharmacy Benefit Limitations	
Nicotine Cessation – Maximum Benefit Per Calendar Year by Participating Retail Pharmacy	Limit of 168-day-supply of each product in one year of treatment $0 Copayment
Prescription Drugs dispensed by non-Participating Pharmacy	Use of a non-Participating Pharmacy requires payment for the Prescription upfront. The Covered Person may then submit a claim reimbursement form with a receipt to CVS Caremark. Reimbursement for covered Prescription Drugs will be based on the lowest contracted amount of a Participating Pharmacy minus any applicable cost share shown on this Schedule.

Note:

- A Copayment may not apply to preventive Prescriptions and over-the-counter products and contraceptives.
- When the Covered Person purchases a brand-name product that has a generic equivalent, he or she must pay the applicable brand-name Copayment plus the difference in cost between the generic Drug and the brand-name Drug when the medical professional has not specified a brand-name Drug or has not indicated that the brand-name Drug is Medically Necessary.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – Black Plan
CVS Caremark

Benefit Plan(s) 005, 006 – Black Plan
Qualified High Deductible Plan

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact CVS Caremark at 866-818-6911 or your employer with any questions related to this coverage or services.

Prescription Drug Plan Deductible, per Calendar Year	Participating Pharmacy
• Per Person • Per Family – *Embedded Deductible* means that under family coverage, all Covered Persons contribute toward the family Deductible, but no individual will pay more than their own individual deductible. Medical and Pharmacy Covered Expenses are subject to the same Medical Deductible	$5,000 $10,000

Out-of-Pocket Maximum, per Calendar Year	Participating Pharmacy
• Per Person • Per Family – *Embedded Out-of-Pocket Maximum* means that under family coverage, all Covered Persons contribute toward the family Out-of-Pocket Maximum, but no individual will pay more than their own individual Out-of-Pocket Maximum. Medical and Pharmacy Covered Expenses are subject to the same Out-of-Pocket Maximum	$6,000 $12,000

Covered Prescription Drug Expenses	Participating Pharmacy
Retail up to a 31-Day Supply (if purchased from a participating retail pharmacy)	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred medications	Deductible, then 10% Coinsurance

Retail up a 93-Day Supply (if purchased from a participating retail pharmacy)	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred medications	Deductible, then 10% Coinsurance

CVS Caremark Mail Order up to a 93-Day Supply	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name medications and non-preferred medications	Deductible, then 10% Coinsurance
Specialty Drugs up to a 31-Day Supply	
CVS Caremark Specialty Pharmacy must be used to fill specialty medications	
• **Tier 1:** Copayment, per Prescription or refill, for Generics and some Brand-name medications	Deductible, then 10% Coinsurance
• **Tier 2:** Copayment, per Prescription or refill, for preferred Brand-name and some Generic medications	Deductible, then 10% Coinsurance
• **Tier 3:** Copayment, per Prescription or refill, for non-preferred Brand-name and non-preferred	Deductible, then 10% Coinsurance
Note: Prior Authorization on Specialty and other select medications may apply. For further information, call CVS Caremark at 866-818-6911.	

Specific Pharmacy Benefit Limitations	
Nicotine Cessation – Maximum Benefit Per Calendar Year by Participating Retail Pharmacy	180 days $0 Copayment
Prescription Drugs dispensed by non-Participating Pharmacy	Use of a non-Participating Pharmacy requires payment for the Prescription upfront. The Covered Person may then submit a claim reimbursement form with a receipt to CVS Caremark. Reimbursement for covered Prescription Drugs will be based on the lowest contracted amount of a Participating Pharmacy minus any applicable cost share shown on this Schedule.

Note:

- A Copayment may not apply to preventive Prescriptions and over-the-counter products and contraceptives.
- When the Covered Person purchases a brand-name product that has a generic equivalent, he or she must pay the applicable brand-name Copayment plus the difference in cost between the generic Drug and the brand-name Drug when the medical professional has not specified a brand-name Drug or has not indicated that the brand-name Drug is Medically Necessary.

OUT-OF-POCKET EXPENSES AND MAXIMUMS – Blue Plan

Benefit Plan(s) 001 – Blue Plan

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

If You have family coverage, any combination of covered family members may help meet the maximum family Deductible, up to each person's individual Deductible amount.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs apply toward the in-network out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Out-of-Network Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.

- Out-of-Network Co-pays and Plan Participation amounts for Prescription products.
- Expenses for substance abuse and chemical dependency.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

If You have family coverage, any combination of covered family members may help meet the maximum family out-of-pocket, up to each person's individual out-of-pocket amount.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

OUT-OF-POCKET EXPENSES AND MAXIMUMS – Silver and Black Plan

Benefit Plan(s) 003, 004,005, 006– Silver Plan, Black Plan

DEDUCTIBLES

(Applies to Benefit Plan(s) 003 and 004 – Silver Plan) A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. If you have family coverage, one person can satisfy the family Deductible. When a new Plan Year begins, a new Deductible must be satisfied.

(Applies to Benefit Plan(s) 005 and 006 – Black Plan) A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan. However, certain covered benefits may be considered Preventive / Routine Care and paid first dollar.

The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person Incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person Incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

(Applies to Benefit Plan(s) 003 and 004 – Silver Plan) The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If you have family coverage, one person can satisfy the family out-of-pocket. If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of Covered Expenses through the end of the Plan Year.

(Applies to Benefit Plan(s) 005 and 006 – Black Plan) The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Out-of-network Co-pays.
- Penalties, legal fees, and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Out-of-network Co-pays and Plan Participation amounts for Prescription products.
- Out-of-network individual and family Deductibles.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person Incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person Incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person’s claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

The Covered Person’s ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan’s Deductible.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 30 calendar days of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An Employee is eligible for health coverage if either:

- They qualify as full-time under ACA look-back measurement rule; or
- Are regularly scheduled to work at least 20 hours per week regardless of full-time status under the ACA look-back measurement rules.

For purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis.

An **eligible Dependent** includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).

- A Dependent does not include the following:
  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - Any other relative or individual unless explicitly covered by this Plan;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
- A Totally Disabled Dependent Child age 26 or over must be unmarried.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan can ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month.

- If You are a part-time Employee and become a full-time Employee at a later date, any time worked as a part-time Employee will be credited toward the 30-day eligibility period shown above. Your coverage will become effective on the first day of the month after You complete the eligibility period.

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or

- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 31 days following the event; or

- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives each eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other health coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents' coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents <u>may not</u> enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 31 calendar days of the marriage, birth, adoption, or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the date of the marriage (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

SPOUSAL TRANSFER PROVISION

If both spouses are Employees and each has taken single coverage under this Plan, this Plan permits Your spouse to take coverage as Your Dependent at any time.

In addition, if both spouses are Employees and eligible for coverage under this Plan and Your spouse previously waived coverage as an Employee in favor of coverage as Your Dependent, this Plan permits Your spouse to take coverage as an Employee under the Plan and to enroll You and any other eligible Dependents as Dependents of Your spouse when:

- You and Your spouse decide to transfer coverage under the Plan from one spouse to the other;
- Your spouse decides to take coverage as an Employee for any reason; or
- You terminate Your coverage under the Plan for any reason.

Your spouse must elect coverage under this Plan within 31 days of the date Your coverage ends to be a timely enrollment. Your spouse's coverage under this Plan will be effective on the day Your coverage ends.

If Your spouse applies more than 31 days after the date Your coverage ends, You will be late applicants under the Plan.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

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

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period as defined by the Affordable Care Act (ACA) in which You became a member of a non-covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The day of the month in which Your Dependent no longer qualifies as a Domestic Partner; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment Section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or

- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent Child submits a false claim or involved in any other fraudulent act related to this Plan or any other group plan.

Note: Once You have enrolled in the Plan, You may not terminate Your election for the current Plan year, but You may change Your election for the following Plan year during the annual open enrollment period. However, if You experience a Qualifying Life Event which includes the following: birth or adoption of a Child; marriage, divorce, legal separation; death of the Employee and/or the Employee's Dependents; spouse and/or Dependent gaining coverage through new employment; substantial changes in the benefits or cost of the Plan or open enrollment under another group Plan, You may be eligible to terminate Your election under this Plan mid-year. To make changes due to Qualifying Life Event listed above, the change must be requested within 31 days of the event and the change in Your election must be consistent with the Qualifying Life Event.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

EXTENSION OF BENEFITS

No benefits will be paid after coverage terminates except as provided below:

- Benefits will be paid for covered charges Incurred before the termination of coverage.
- If coverage terminates for any reason other than the Plan being canceled or fraud being committed against the Plan, a Covered Person may be eligible for the following extension:
  - If You are Totally Disabled on the date Your coverage under this Plan would otherwise terminate, coverage will be extended, but only for the treatment of the Illness or Injury causing Your Total Disability. Your extended coverage will remain in force for up to the earliest of the following dates:
    - The date Your Total Disability ends; or
    - Six consecutive months from the date Your coverage would otherwise ended.

    At the end of the six month period, COBRA continuation will be offered.

Benefits will be paid only for the Illness or injury for which the Covered Person is Totally Disabled and only to the same extent they would have been if the coverage had not been terminated. The Covered Person must pay the same contribution towards the premium each month that active Employees pay. Payment is due by the first day of each month for which coverage is provided. COBRA coverage, if elected, will run concurrently with this extension of benefits period, subject to all COBRA regulations and premium payments as described in this document.

COBRA CONTINUATION OF COVERAGE

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend the Length of COBRA Continuation Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if he or she loses coverage under the Plan because one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee's hours of employment are reduced	up to 18 months
• The Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to either Your employer or to the COBRA administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA administrator is available upon request.)

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that he or she must complete, in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment Provision section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
BAYCARE HEALTH SYSTEMS, LLC
1035 KEPLER DR
GREEN BAY WI 54311

The COBRA Administrator:
BAYCARE HEALTH SYSTEMS, LLC
1035 KEPLER DR
GREEN BAY WI 54311

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- a period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator's reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
- The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Physician may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider's balance bill.

PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  BayCare Health Systems

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

The program for Transplant Services at Designated Transplant Facilities is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Non-air Ambulance transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, pathologist, cardiologist and ER Physician will be payable at the In-Network level of benefits when services are provided at a Network facility, depending on the original provider tier or referred by an In-Network Physician, depending on the original provider tier, even if the provider is an Out-of-Network provider.
- Covered services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital based on the tier level.

- If Your condition requires Emergency medical care, non-network provider services will be payable at tier one level.
- If you receive covered services that are not available through a Tier 1 provider, these services can be considered under the Tier 1 benefit. You must provide BayCare Human Resources with the bill and background information regarding the services provided as well as an explanation of why there was not a Tier 1 provider available.

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

If You meet the requirements for Continuity of Care under applicable law or Network contract, the In-Network benefit level may continue for certain medical conditions and timeframes despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents generally need to be under a continuing treatment plan by a provider or facility who was a member of the participating Network and:

- Undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- Undergoing Inpatient or institutional care;
- Scheduled for non-elective surgical care, including necessary postoperative care;
- Pregnant and being treated; or
- Terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization is recommended prior to obtaining services. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

1. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

2. **Acupuncture Treatment.**

3. **Allergy Treatment,** including: Injections, testing and serum.

4. **Ambulance Transportation:**

   - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
   - Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

6. **Aquatic Therapy.** (See Therapy Services below.)

7. **Augmentation Communication Devices** and related instruction or therapy, when Medically Necessary.

8. **Autism Spectrum Disorders (ASD) Treatment**.

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

9. **Bariatric / Obesity Surgery**: Surgical treatment of obesity provided by or under the direction of a Physician either of the following is true:

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

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

   - You have documentation from a Physician of a diagnosis of morbid obesity for a minimum of three years;
   - You are over the age of 18;
   - The surgery is performed at a **Plan Tier 1 Hospital (normal plan benefits)** by a Tier 1 surgeon even if there are no Tier I Hospitals near You; and

   The Physician requesting authorization for the surgery must confirm all of the following:

   - The patient's psychiatric profile is such that the patient is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements;
   - The patient's post-operative expectations have been addressed;
   - The patient has undergone a pre-operative medical consultation and is felt to be an acceptable surgical candidate;
   - The patient has undergone a pre-operative mental health consultation and is felt to be an acceptable candidate;
   - The patient has received a thorough explanation of the risks, benefits and uncertainties of the procedures;
   - The patient's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling; and
   - The patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.

10. **Biofeedback Services.**

11. **Blood and blood plasma** that is not replaced by donation. Blood and blood products including blood extracts or derivatives are covered.

12. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, limits on duration, or the type of equipment that is covered.

13. **Breast Reductions** if Medically Necessary.

14. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period, and costs for renting breastfeeding equipment.

15. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.

16. **Cardiac Rehabilitation** programs (when Medically Necessary), if referred by a Physician, for patients who have certain cardiac conditions including, but not limited to, the following:

    - the Covered Person had a heart attack in the last 12 months; or
    - the Covered Person had coronary bypass surgery; or
    - the Covered Person had a stable angina pectoris.

Covered services include:

- Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
- Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

17. **Cataract or Aphakia Surgery** as well as surgically implanted protective lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

18. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

19. **Cleft Palate and Cleft Lip,** including Medically Necessary oral surgery and pre-graft palatal expanders.

20. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive mobile app subscription (e.g., Natural Cycles).
    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

21. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

22. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), including implants. The initial visit should be Incurred within 72 hours of the Accident. Replacement expense must be started within three months of the Injury and must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

23. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

24. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same for any other Illness.

25. **Durable Medical Equipment,** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse, misuse, loss, or theft, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.

26. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

27. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

- Room and board.
- Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

28. **Eye Refractions** if related to a covered medical condition.

29. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
- Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

30. **Gender Dysphoria:** Benefits for the Medically Necessary treatment of Gender Dysphoria provided by or under the direction of a Physician. For the purpose of this benefit Gender Dysphoria is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Surgeries that alter physical appearance only and are not for the treatment of Gender Dysphoria are not covered by the Plan.

    This Plan provides an allowance for reasonable travel and lodging expenses, up to the maximum listed on the Medical Schedule of Benefits, if any, for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the covered health services from an available Network provider. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. Travel and lodging reimbursements that exceed IRS limits may be subject to IRS codes for taxable income. If You would like additional information regarding travel and lodging, You may contact us at the telephone number on Your ID card.

31. **Genetic Counseling** based on Medical Necessity.

32. **Genetic Testing** when Medically Necessary (see below).

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. In some cases, testing may be accompanied with pre-test and post-test counseling.

    Genetic testing must also meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors or a particular family history that indicates a genetic cause.
    - The patient meets defined criteria that place him or her at high genetic risk for the condition.

    Generally, genetic testing is not covered for:

    - Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies
    - Informational purposes alone (e.g., testing of minors for adult-onset conditions and self-referrals or home testing)
    - Experimental, Investigational, or Unproven purposes.

33. **Growth Hormones.**

34. **Hearing Services** include:

    - Exams, tests, services, and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids.
    - Implantable hearing devices if Medically Necessary.

35. **Home Health Care Services:** (Refer to Home Health Care section of this SPD.)

36. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

    - **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
    - **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **Bereavement Counseling:** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within twelve months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

37. **Hospital admission kits.**

38. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- Semi-private and private room and board services:
  - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
  - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or the Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

39. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

40. **Implanted Electrical Spinal Cord Stimulators:** Tier 1 Physician & Tier 1 Hospital only (normal plan benefits).

41. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person.

Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

42. **Insulin Infusion Pump,** its installation and use including other equipment and supplies used in the treatment of diabetes, if they are not covered under the Prescription drug card (except diabetic test strips).

43. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.

44. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

45. **Maternity Benefits** for the Employee or spouse include:

- Hospital or Birthing Center room and board.
- Vaginal delivery or Cesarean section.
- Non-routine prenatal care.
- Postnatal care.
- Medically Necessary diagnostic testing.
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Outpatient Birthing Centers.
- Home births.
- Midwives.

46. **Medical and/or Routine Services Provided in a Foreign Country**, except that no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies.

47. **Mental Health Treatment.** (Refer to the Behavioral Health Benefits section of this SPD.)

48. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

49. **Nutritional Counseling** for preventive services that are required under the United States Preventive Services Task Force and/or for the treatment of medical and behavioral/mental health conditions.

50. **Nutritional Supplements, Vitamins, and Electrolytes**. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

51. **Occupational Therapy.** (See Therapy Services below.)

52. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.
- Frenectomy (the cutting of the tissue in the midline of the tongue).
- Gingival mucosal surgery (gingivectomy, osseous, periodontal surgery, and grafting) to treat gingivitis or periodontitis.
- Apicoectomy (the excision of the tooth root without the extraction of the entire tooth).
- Excision of exostosis of jaws and hard palate.
- Alveolectomy (leveling of structures supporting teeth for the purpose of fitting dentures). However, this service is not covered if performed in conjunction with routine extraction of natural teeth.
- Removal of retained residual root.
- Gingival curettage.
- Apical curettage.

53. **Orthotic Appliances, Devices, and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

54. **Oxygen and Its Administration.**

55. **Panniculectomy** when Medically Necessary.

56. **Pharmacological Medical Case Management** (medication management and lab charges).

57. **Physical Therapy.** (See Therapy Services below.)

58. **Physician Services** for covered benefits.

59. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

60. **Prescription for Health Benefit.** Dependent Children are not eligible for this program.

61. **Prescription Medications** that are administered or dispensed as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

62. **Preventive / Routine Care** as listed under the Schedule of Benefits.

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

    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
    - Well-Woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

      - Screening for gestational diabetes;
      - Human papillomavirus (HPV) DNA testing;
      - Counseling for sexually transmitted infections;
      - Counseling and screening for human immune-deficiency virus; and
      - Screening and counseling for interpersonal and domestic violence; and
      - Breast cancer genetic test counseling (BRCA) for women at high risk.

Please visit the following links for additional information:

https://www.healthcare.gov/preventive-care-benefits/
https://www.healthcare.gov/preventive-care-children/
https://www.healthcare.gov/preventive-care-women/

63. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts.

64. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly consistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

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

  - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);

- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
- The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - It is comparable to the system of peer review of studies and investigations used by the NIH; and
  - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

65. **Radiation Therapy and Chemotherapy.**

66. **Radiology and Interpretation Charges.**

67. **Reconstructive Surgery** includes:

    - Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, by an Accident, or from an infection or other disease of the involved part.

68. **Respiratory Therapy.** (See Therapy Services below.)

69. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

70. **Sleep Disorders** if Medically Necessary.

71. **Sleep Studies.**

72. **Speech Therapy.** (See Therapy Services below.)

73. **Sterilizations.**

74. **Substance Use Disorder Services.** (Refer to the Behavioral Health Benefits section of this SPD.)

75. **Surgery and Assistant Surgeon Services.**

76. **Taxes:** Sales tax for medical records.

77. **Telehealth.** Consultations made by a Covered Person to a Physician.

78. **Temporomandibular Joint Disorder (TMJ) Services** include:

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

    Coverage does not include orthodontic services.

79. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT), Licensed Athletic Trainers (LAT) or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
    - **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
    - **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

80. **Threaded Carpal Tunnel:** Tier 1 Physician & Tier 1 hospital only (normal plan benefits).

81. **Threaded Trigger Finger:** Tier 1 Physician & Tier 1 hospital only (normal plan benefits).

82. **Tissue Transplants.**

83. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law and diagnoses, services, treatment, and supplies related to addiction to or dependency on nicotine. Services required to obtain a Prescription for smoking cessation or nicotine addiction Prescription drugs.

84. **Transplant Services.** (Refer to Transplant section of this SPD.)

85. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

86. **Vision Care Services.** (Refer to Vision Care section of this SPD.)

87. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

88. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

89. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

It is recommended that Covered Person obtain prior authorization before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge for the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the UMR CARE section of this SPD for prior authorization requirements

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan’s Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by **CVS Caremark**

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact CVS Caremark at 866-818-6911 or Your employer with any questions related to this coverage or services.

PLAN ADMINISTRATOR/PLAN SPONSOR:
BayCare Health Systems, LLC
1035 Kepler Dr
Green Bay, WI 54311
Phone: 920-490-9046

THE PHARMACY BENEFITS ADMINISTRATOR FOR THIS PLAN IS:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Customer Care Number: 1-866-818-6911
Member Portal: www.Caremark.com

CVS Caremark Member Customer Care
1-866-818-6911

CVS Caremark Mail Service
1-866-239-4543

CVS Specialty Pharmacy
1-800-237-2767

This Prescription Drug Coverage section describes the Prescription Drug benefits available to you under the BayCare Health Systems, LLC Group Benefit Plan (the "Plan") to which these benefits are integrated. When you (and your eligible dependents) enroll in the Plan you are eligible to receive Prescription Drug benefits, you do not need to make a separate election.

NATIONAL COOPERATIVERX AND CVS CAREMARK

The employer is a member of National CooperativeRx, a group purchasing cooperative designed to help participating members and their employees maximize the return on their Prescription drug expenses. As a member of National CooperativeRx, the Employer has contracted with CVS Caremark to provide pharmacy management services to the Prescription Drug Plan. CVS Caremark acts as the pharmacy benefits manager and is sometimes referred to as a "PBM" or "Rx administrator". Members may contact CVS Caremark as noted above and elsewhere in this section.

DISCREPANCY

The Prescription Drug benefits listed will supersede any Prescription Drug benefit provisions in the Plan's medical Plan Document, Summary Plan Description (SPD), benefit booklets, prior summaries, and addenda as well as any oral communication. The Prescription Drug benefits described herein are only available for eligible expenses incurred while this coverage is in force and are not payable for expenses incurred before coverage began or after coverage terminates. An expense for an item or service is incurred on the date the item or service is furnished or provided.

ELIGIBILITY FOR BENEFITS

To receive coverage under this Prescription Drug benefit, eligible employees and their eligible dependents must be enrolled under the Plan. Coverage under the Prescription Drug benefits will be effective at the same time coverage under the Medical Plan begins.

Enrollment

An eligible employee or eligible dependent enrolled for coverage under the Medical Plan will be enrolled automatically under the Prescription Drug benefits. Eligible employees are neither required nor permitted to make separate enrollment elections for themselves or their eligible dependents under the Prescription Drug benefits.

Termination of Coverage

Coverage under the Prescription Drug benefits will continue until the Member's coverage under the Medical Plan ends. If the Member timely elects to continue his or her Medical Plan coverage pursuant to COBRA or other coverage continuation provisions under the Medical Plan, then coverage under Prescription Drug benefits will also continue.

DEFINITIONS

"Coinsurance"
"Coinsurance" shall mean a cost sharing feature of many plans which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Prescription Drug expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her medical plan design.

"Copayment" or "Copay"
"Copayment" or "Copay" shall mean that portion of the charge for each covered Drug dispensed to the Member that is the responsibility of the Member (e.g., Copayment, Coinsurance).

"Deductible" (Applicable to Benefit Plans 003, 004, 005 and 006)
"Deductible" is combined between these Prescription Drug benefits and your medical benefits under the plan, and the term shall mean the same as such is explained or defined in the "Medical Schedule of Benefits" section of the Plan.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without Prescription," or a State restricted Drug (any medicinal substance which may be dispensed only by Prescription, according to State law), legally obtained and dispensed by a licensed Drug dispenser only, according to a written Prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Formulary"
"Formulary" means the list of FDA-approved Prescription Drugs offered by CVS Caremark and adopted by the Employer for this Medical Plan.

"**Out of Pocket Maximum**"
"Out-of-Pocket ("OOP") Maximum" is combined between these Prescription Drug benefits and your medical benefits under the Plan, and the term shall mean the same as such is explained or defined in the Out-of-Pocket Expenses and Maximums" section of the Plan.

"Participant"
"Participant" shall mean an employee and/or his or her dependent(s) who satisfies the eligibility and participation requirements specified in the Plan and is enrolled in the Plan.

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Participating Pharmacy"
"Participating Pharmacy" means a retail, mail-order, or specialty pharmacy, including any chain or independent location, that has entered into a written agreement with the Plan or its pharmacy benefit manager to dispense Covered Drugs to Members and to accept the applicable reimbursement rates, billing procedures, and utilization management requirements.

OTHER IMPORTANT PRESCRIPTION DRUG COVERAGE INFORMATION

Covered Drugs

Your Prescription Drug benefit covers most commonly used Federal Legend Drugs, which are Drugs labeled "Caution: Federal law prohibits dispensing without a Prescription." The Plan uses the CVS Caremark formulary, including its preferred drug list, developed by pharmacists and providers to identify the safest, most effective, and most economical medications.

Formulary exclusions are not covered unless CVS Caremark approves a formulary exception. Approval is generally granted only when the excluded drug is clinically necessary and preferred alternatives are ineffective or inappropriate. The preferred drug list may change periodically and is available on www.caremark.com. Not all products or formulations of a listed drug are covered.

Your pharmacist or prescribing Physician can confirm drug coverage by contacting CVS Caremark at the number on your Prescription ID card. A full list of covered and excluded Drugs is available at www.caremark.com or from your employer upon request at no cost.

Drug Coverage Limitations

The benefits set forth in this section will be limited to:

Dosages.
1. With respect to the Retail 31-day option, any one Prescription is limited to a 31-day supply.
2. With respect to the Mail Order 93-Day any one Prescription is limited to a 93-day supply using CVS Caremark Mail-Order only.
3. With respect to the Specialty Drugs 31-Day option, any one Prescription is limited to a 31-day supply.

Refills.
1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

Specialty Medications

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through an approved CVS Caremark specialty pharmacy and may be subject to Prior Authorization. Some exceptions may apply. Specialty medications are generally limited to a 30-day supply. Specialty medications largely fall into the formulary brand category but could also fall into the other coverage categories. All specialty medication questions should be directed to:

CVS Specialty Pharmacy
1-800-237-2767
www.CVSSpecialty.com

Value of Drug Manufacturer Assistance

If any amount of your Deductible or required Coinsurance/Copay listed in the Schedule of Benefits section of this plan document, are paid or reimbursed by a manufacturer assistance program, copay cards, or similar patient assistance program from a third party, that amount covered by the third party will not accrue toward the Deductible or Out-of-Pocket Maximum.

CVS Caremark National Pharmacy Network

Members may receive Plan benefits from any Participating Pharmacy within the CVS Caremark National Pharmacy Network (to include retail Pharmacies, Mail Order Pharmacies and Specialty Pharmacies). This network includes most major chains as well as independent pharmacies. Members can search for network pharmacies on the CVS Caremark website at www.CVS Caremark.com, smartphone app, or by calling customer care. Members should contact CVS Caremark for any questions or issues concerning network access. The applicable Copayment/Coinsurance amounts listed on the Schedule of Benefits are applied to each Prescription Drug you purchase at a Participating Pharmacy.

Note: If you have had to purchase a covered Prescription Drug at full price because you did not have your Prescription card, you must give CVS Caremark written proof of claim within 12 months after the date the expenses are incurred. You may obtain any required forms from caremark.com and CVS Caremark will review your paper claim and notify you if more information is necessary. Any claims submitted after 12 months from the date of the sale/expenses are incurred will not be reimbursed.

Mail Order Prescription Drugs

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). CVS Caremark is a low-cost leader in the marketplace for Prescription Drugs, and CVS Caremark is able to pass along substantial savings on medication to you and your benefit plan when you use the CVS Caremark Mail Order Pharmacy.

You can get started with Mail Service in a variety of ways:

1. Call CVS Caremark (1-866-818-6911). Have your ID card, doctor's contact information, Prescription information, and payment method ready.
2. Log in to your Caremark.com account. Select "Prescriptions" from the toolbar and then select "Start Mail Service" to request a new Prescription for use at mail service.
3. Ask your prescriber to call, e-prescribe or fax your Prescription information to Caremark Mail Service.
   a. *Phone: 1-800-378-5697*
   b. Fax: 1-800-378-0323
   c. E-prescribe: CVS Caremark Mail Service, NCPDP ID 322038, 9501 E. Shea BLVD., Scottsdale, AZ 85260
4. Mail a hard copy 90-day Prescription and a completed Mail Service order form to CVS Caremark. Allow at least two weeks for delivery. Ask your doctor for a 30-day Prescription you can fill at a retail pharmacy while you wait for the mail order delivery if you choose this option. A Mail Service order form can be found online at www.caremark.com, under "print plan forms" in the upper right-hand corner of the website.

Preventive Care Services Covered Under the Affordable Care Act

The plan offers certain preventive Prescription drugs at no cost to Covered Members. Preventive drugs are deemed preventive by the United States Preventive Services Task Force. Some services may be covered under the Plan while others may be covered under your medical benefit. These no-cost benefits are part of the Affordable Care Act (ACA). A current list of services may be found at www.hhs.gov.(see *Preventive Services Covered Under the Affordable Care Act)*. This list is subject to change. Limitations may apply. These items require a written Prescription from a medical professional.

Non-Participating Pharmacy Claims

If a Covered Member uses a non-Participating Pharmacy, the Covered Member will need to pay the full amount billed by the pharmacy and submit a paper claim for possible reimbursement. Requests for reimbursement can be submitted in one of two ways:

1. Electronically via a Covered Member's caremark.com account. Online submission allows for faster processing and provides real time updates on the status of the claim.

2. By completing a Prescription Claim Submission Form and returning it via the mail. Mail in submissions usually take up to 30 days processing from the date in which they are received by Caremark. The claim submission form may be obtained on caremark.com. Covered Member's must submit the form along with the receipt for reimbursement to the following address:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

These claims will be reimbursed at the participating pharmacy's negotiated contract rate, less the applicable Member cost share. Any difference between the pharmacy's billed rate and the contract or negotiated rate is an additional cost the Member will incur. This difference will not count towards the Plan's Deductible or Out-of-Pocket Maximum as applicable. Reimbursement will be subject to prior authorization, utilization management, and formulary management requirements where applicable.

Coordination of Benefits

The Prescription Drug benefits section of the Plan does coordinate benefits.

PRIOR AUTHORIZATION

Prior Authorization requirements are placed on certain medications to increase appropriate utilization, promote treatment or step-therapy protocols, actively "risk manage" Drugs with serious side effects, and influence the process of managing costs.

Drugs with a Prior Authorization requirement are designated on the formulary with a "PA" indicator.

All **non**-specialty Drug prior authorizations will be handled by CVS Caremark and all specialty Drug appeals
will be handled by National CooperativeRx as outlined below:

Non-Specialty Prior Authorization Department-CVS Caremark Prior Authorization Department
Phone: 1-800-294-5979
Fax: 1-888-836-0730

Specialty Prior Authorization Department-National CooperativeRx
Phone: 1-608-416-8702 or toll free 1-877-205-6592
Fax: 1-866-278-8190

REVIEW AND APPEAL PROCEDURES

A Covered Person has the right to request that a medication be covered or be covered at a higher benefit (e.g., a lower Copay, higher quantity, etc.). All non-specialty Drug appeals will be handled by CVS Caremark. All specialty Drug appeals will be handled by National CooperativeRx. To initiate a first or second level appeal, Covered Persons are directed to:

Non-Specialty Appeals – CVS Caremark - *Can be submitted in writing via fax or mail.*
Prescription Claim Appeals MC 109 CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

Specialty Appeals-National CooperativeRx - *Can be submitted in writing via fax or mail.*
National CooperativeRx Prescription Claim Appeals
2418 Crossroads Drive Suite 2600
Madison, WI 53718
Fax: 1-866-278-8190

For more information concerning the timing or other requirements related to filing a first level appeal, second level appeal, or an external review appeal (if eligible), please contact CVS Caremark at 1-866-443-1172 for non-specialty Drugs, and National CooperativeRx at 1-866-818-6911 for specialty Drugs.

CUSTOMER CARE

If you have questions about your Prescription Drugs or Prescription Drug benefits, you can contact CVS Caremark Customer Care 24 hours a day, seven days a week, including holidays, at 1-866-818-6911 or www.caremark.com.

MEDICALRX ADVISOR

Certain Specialty Pharmaceutical Products are eligible for coupons, offers, assistance programs, or discounts (Coupons) from pharmaceutical manufacturers or affiliates that may reduce the cost of Your Specialty Pharmaceutical Product. The claims administrator may help You determine whether Your Specialty Pharmaceutical Product is eligible for this reduction. If You are eligible and redeem a Coupon from a pharmaceutical manufacturer or affiliate, Your applicable Deductible, Copay, and/or Plan Participation may vary (this is known as an Adjusted Variable Copayment) and will be reflected as Deductible, Copay, and/or Plan Participation in Your Explanation of Benefits. Plan payment will be determined based on the difference of the allowed amount minus the Adjusted Variable Copayment described above. The redeemed Coupon value will not count toward any applicable Deductible or out-of-pocket limits. Please contact www.umr.com or the telephone number on Your ID card for an available list of Specialty Pharmaceutical Products. If You choose not to participate, You will pay the applicable Deductible, Copay, and/or Plan Participation as described in the Medical Schedule of Benefits.

VISION CARE BENEFITS

The Plan will pay for Covered Expenses for vision care Incurred by a Covered Person, subject to any required Deductible, Copay if applicable, Plan Participation amount, maximums, and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Negotiated Rate.

COVERED BENEFITS

- Eye exam.
- Refraction.
- Optomap Retinal Imaging
- Vision therapy services (including orthoptics) or supplies.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices, whether or not prescribed by a Physician or optometrist.
- Correction of visual acuity or refractive errors.
- Aniseikonia.
- Lenses.
  - Single.
  - Bifocal.
  - Trifocal.
  - Lenticular.
  - Progressive.
- Frames.
- Elective contacts.
- Necessary contacts.
- Contact lens fitting.
- Safety lenses and frames.
- Eye surgeries used to improve or correct eyesight for refractive disorders, including LASIK surgery, radial keratotomy, refractive keratoplasty or similar surgery.

BEHAVIORAL HEALTH BENEFITS

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

Covered Benefits

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

Additional Provisions And Benefits

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

SUBSTANCE USE DISORDER BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

Covered Benefits

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Substance Use Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

Additional Provisions And Benefits

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment, and all counseling or therapy notes, and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and at the appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. In general, when the Covered Person receives services from a Managed Care UnitedHealthcare Network Provider or facility, the provider or facility is responsible for obtaining the Prior Authorization. However, the Covered Person should ensure that the provider completes all required Prior Authorizations before services are rendered. If the Covered Person is not receiving covered health care services from a Managed Care UnitedHealthcare Network Provider, the Covered Person is responsible for ensuring that any required Prior Authorizations are completed before services are received. In that case, the Covered Person is responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for Medical Necessity review as required by the Plan. In addition to the requirement to notify and obtain Prior Authorization of a service or procedure in advance, all admissions to a facility also require a notification within 24 hours of the admission. If the stay is accessing a Managed Care UnitedHealthcare Network Provider, that facility must provide timely admission Notification (even if advance Notification was provided by the Physician and pre-service clinical approval is on file). If it is not a Managed Care UnitedHealthcare Network Provider the Covered Person is responsible for ensuring the facility completes that Notification.

Special Notes: A Covered Person who could reasonably expect that the absence of immediate, or Emergency, medical attention would jeopardize the life or long-term health of the individual is responsible for ensuring the provider contacts the Utilization Review Organization as soon as possible through the umr.com portal, by phone, or by fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Managed Care UnitedHealthcare Network Providers are providers participating in any UnitedHealthcare Network product with the exception of Options PPO.

Prior Authorization / Notification is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

CARE PROVISIONS

Complex Condition CARE

Complex Condition CARE is available to all Covered Persons. CARE nurse managers review available clinical information from utilization activity and other available resources to identify anticipated member needs. Collaboration with the member, caregiver, and provider is initiated to coordinate care in order to address gaps and barriers with the goal of reducing readmissions and/or complications. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.
- management of catastrophic and complex behavioral health and substance use disorders and support for identified members utilizing Inpatient/rehabilitation/residential facilities.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. It does not, however, apply to Prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

(Applies to Benefit Plan(s) 001 – Blue Plan) The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

(Applies to Benefit Plan(s) 003, 004, 005, 006 – Silver Plan, Black Plan) The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- If an individual is covered under one plan as a Dependent and another plan as an Employee, member, or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active Employee (or Dependent of an active Employee), and is also covered under another plan as a retired or laid-off Employee (or Dependent of a retired or laid-off Employee), the plan that covers the person as an active Employee (or Dependent of an active Employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an Employee, member, subscriber, or retiree the longest is primary.

- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

When this Plan is not primary and a Covered Person is receiving Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payments on Medicare Part B services as though Medicare Part B was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:

  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.

  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.

  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstances:

  - You are no longer actively employed by an employer; and

  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or

  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

- You or Your covered spouse has retiree coverage plus Medicare coverage; or
- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as primary payer.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, Your representative(s), Your Dependents, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are allegedly related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity against whom You may have any claim arising out of any alleged wrongful or bad faith conduct by such person or entity.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or Injuries.
    - Making court appearances.
    - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

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

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

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, no matter how those proceeds are allocated, captioned, characterized, or classified, and regardless of the theory of recovery. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, bad faith, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

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

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party allegedly arising out of Illness or Injury and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

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

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery by You or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to a Dependent Child who allegedly incurs an Illness or Injury caused by a third party and to the parents, guardian, or other representative of that Dependent Child. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect from third party recoveries held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **Abdominoplasty.**

2. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term.

3. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

4. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.

5. **Appointment Missed:** An appointment the Covered Person did not attend.

6. **Assistance With Activities of Daily Living.**

7. **Assistant Surgeon Services**, unless determined to be Medically Necessary by the Plan.

8. **Augmentation Communication Devices** and related instruction or therapy, unless determined by the Plan to be Medically Necessary.

9. **Auto Excess:** Benefits are not payable for an Injury or Illness if there is any responsible or liable party providing coverage for health care expenses You incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent.

10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

11. **Blood:** Blood donor expenses.

12. **Blood Pressure Cuffs / Monitors.**

13. **Braces** that straighten or change the shape of any body part including dental braces.

14. **Breast Pumps,** unless covered elsewhere in this SPD.

15. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

16. **Chelation Therapy,** except in the treatment of conditions considered to be Medically Necessary, medically appropriate, and not Experimental, Investigational, or Unproven for the medical condition for which the treatment is recognized.

17. **Claims** received later than 15 months from the date of service.

18. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

19. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

20. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan.

21. **Custodial Care** as defined in the Glossary of Terms of this SPD.

22. **Dental Services,** unless covered elsewhere in this SPD.

23. **Developmental Delays:** Medical charges and occupational physical, or speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy.

24. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

25. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.

26. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

27. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

28. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, or the Negotiated Rate. This exclusion does not apply to payments that may be required under the No Surprises Act.

29. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

30. **Extended Care:** Any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.

31. **Family Planning:** Consultations for family planning.

32. **Fetal reduction surgery.**

33. **Financial Counseling**.

34. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

35. **Foot Care (Podiatry):** Routine foot care.

36. **Genetic Counseling** other than based on Medical Necessity, unless covered elsewhere in this SPD.

37. **Genetic Testing,** unless covered elsewhere in this SPD.

38. **Health check-ups or routine exams and immunizations,** except as stated; prophylactic surgery to prevent Illness that has not occurred yet; or third party-exams, including but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment , school, travel or the purchase of insurance; unless specifically stated as a Covered Expense.

39. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

40. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

41. **Infertility Treatment:**

    - Fertility tests.
    - Surgical reversal of a sterilized state that was a result of a previous surgery.
    - Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs.
    - Artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Genetic testing.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered person.

42. **Lamaze Classes** or other childbirth classes.

43. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for the primary diagnosis of a Learning Disability. If another medical or behavioral/mental health condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

44. **Liposuction,** regardless of purpose.

45. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

46. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

47. **Marriage Counseling,** unless covered elsewhere in this SPD**.**

48. **Massage Therapy.**

49. **Maternity Costs Other Than Routine Prenatal Medical Care Expenses** for Covered Persons other than the Employee or spouse.

50. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

51. **Mechanotherapy** or other forms of passive motion therapy, unless specifically approved by the Plan.

52. **Medical and surgical treatment of snoring**, except when provided as part of treatment for documented sleep apnea, oral appliances for snoring.

53. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

54. **Nocturnal Enuresis Alarm.**

55. **Non-Custom-Molded Shoe Inserts.**

56. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

57. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

58. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

59. **Nutritional Counseling,** unless covered elsewhere in this SPD.

60. **Nutritional Supplements, Vitamins, and Electrolytes** except as listed under Covered Medical Benefits**.**

61. **Orthognathic, Prognathic, and Maxillofacial Surgery.**

62. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

63. **Palliative Foot Care.**

64. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays.

65. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

66. **Prescription Medication**, that is administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility and that requires a Physician's Prescription. (A Covered Person with a written Physician's Prescription who obtains medication from a pharmacy should refer to the Prescription Benefits section of this SPD for coverage.)

67. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD.

68. **Private Duty Nursing Services.**

69. **Psychosurgery.**

70. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

71. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

72. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

73. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

74. **Safe Driving Practices:** If You are involved in an Accident that results in Injuries that require attention if any of the following apply:

    - You were not wearing an installed seat belt or, for a Dependent Child, such Child was not in approved child restraint or car seat, when involved in a motor vehicle Accident; or
    - You were not wearing a helmet or protective headgear while riding a licensed motorized scooter, motorcycle, snowmobile or all-terrain vehicle.

    The normal Plan benefits will be applied after this $5,000 penalty. This $5,000 penalty is not an annual amount. A separate $5,000 penalty per Covered Person will apply for each and every circumstance, as described above, which occurs during each and every Accident. This $5,000 penalty will not be applied to the Deductible, coinsurance or out-of-pocket maximums shown on the schedule of benefits.

75. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

76. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

77. **Services** that should legally be provided by a school.

78. **Services Provided By a Close Relative,** unless covered elsewhere in this SPD. See the Glossary of Terms section of this SPD for a definition of Close Relative.

79. **Sex Therapy.**

80. **Sexual Function:** Diagnostic service, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

81. **Standby Surgeon Charges.**

82. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

83. **Supplies**: Elastic stockings, ace bandages, gauze and dressings, syringes and diabetic test strips.

84. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

85. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

86. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.

87. **Telemedicine.**

88. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

89. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

90. **Travel:** Travel costs, unless covered elsewhere in this SPD.

91. **Vertebral Axial Decompression (VAX-D).**

92. **Vision Care,** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

93. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

94. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

95. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

96. **Weight Control:** Treatment, services, or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

97. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

98. **Workers' Compensation:** Health care services for which other coverage is required by federal, state, or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation or similar legislation. This exclusion does not apply to employers that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners, and/or partners.

99. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining the medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 15 months from the date of service and 12 months for pharmacy claims and 24 months for workman's compensation claims. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts minus, any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Copay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or urgent care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or urgent care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person’s loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at www.UMR.com to assist you in providing all the recommended information to ensure a full and fair review of your adverse benefit determination. You are not required to use this form.

Send first-level Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Send Pharmacy appeals to:
APPEALS DEPARTMENT MC 109
CAREMARK, INC.
P.O. BOX 52084
PHOENIX, AZ 85072-2084

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services; or
- Determinations relating to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations relating to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;

- Whether an individual gave informed consent to waive the protections under the No Surprises Act;
- Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
- Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or

- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You, or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on his or her appeal.**

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else-such as the Covered Person's spouse or another family member-files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Employee Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator’s principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if they experience a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS’ RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 per day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If You have any questions about this Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post-tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or
- Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

- In an Emergency situation; or
- When deemed Medically Necessary, which is to the closest facility most able to provide the specialized treatment required; and the most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes a husband or wife, Domestic Partner, birth or adoptive parent, Child, sibling, Domestic Partner's Child, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

Domestic Partner means a person of the opposite or same sex, with whom the Employee has a relationship that meets all of the following requirements:

- The partners must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside;
- Each partner must not be currently married to, or a Domestic Partner of, another person under either statutory or common law;
- The partners must share the same permanent residence and the common necessities of life;
- Each partner must at least be 18 years of age;
- Each partner must be mentally competent to consent to contract; and
- The partners must be financially interdependent and have furnished documents to support at least two of the following conditions of that:
  - they have a single dedicated relationship of at least six months duration;
  - they have joint ownership of a residence;
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;
    - a joint credit account;
    - a lease for a residence identifying both partners as tenants; or
    - a will and/or life insurance policies which designates the other as primary beneficiary.

The Employee and Domestic Partner must jointly sign the required affidavit of domestic partnership.

If a domestic partnership is terminated, a Waiting Period of six months applies before another Domestic Partner may be enrolled in the Plan. When a domestic partnership is terminated, You must provide proof of the termination in writing.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

Braces that stabilize an injured body part and braces to treat curvature of the spine are considered to be Durable Medical Equipment. A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the first day of the Waiting Period.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate. The term "Hospital" does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term “Injury” does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual’s achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual’s property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, Substance Use Disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, Substance Use Disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means any disease or condition that falls under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopment disorders in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury. This includes braces that straighten or change the shape of a body part.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed for Adoption or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the BAYCARE HEALTH SYSTEMS, LLC Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

(Applies to Benefit Plan(s) 003, 004, 005, 006 – HDHP Plan) For a High Deductible Health Plan, Preventive / Routine Care means care consistent with IRS Code Section 223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a High Deductible Health Plan (HDHP) without the Covered Person satisfying the minimum Deductible under the Plan.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/Substance Use Disorders, or a Physician assistant / nurse practitioner regardless of specialty or practice type. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

Substance Use Disorder means any disease or condition that falls under the diagnostic categories as a mental or behavioral disorder due to psychoactive substance use listed in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.