Washington County

Medical Benefit Plan

Group Number: 76-440225
Revised: January 1, 2021

IMPORTANT MESSAGE

CHANGES IN ELIGIBILITY

You should report **ANY CHANGE IN ELIGIBILITY** to *your employer* as soon as possible. Changes in eligibility include:

- Marriage or divorce
- Death of any *dependent*
- Birth or adoption of a child
- *Dependent* child reaching the limiting age
- Total disability
- Retirement
- *Medicare* eligibility

For specific details on maintaining coverage under the plan, refer to SECTION 3 - ELIGIBILITY.

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SECTION 1 MEDICAL BENEFITS

NOTE: UMR, Inc. is the *plan's claims administrator*. UMR, Inc. provides clerical and claim processing services to the *plan*. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the *plan*, nor is UMR, Inc. a fiduciary to this *plan*.

SCHEDULE OF BENEFITS

PAYMENT OF COVERED EXPENSES

The Plan will pay for Your Covered Expenses to the extent provided in the Plan, subject to the deductibles, copayments, maximums and all other terms, provisions, limitations, conditions and exclusions of 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:

1. Fee(s) that are negotiated with the physician or facility; or

2. The amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services; or

3. Using current publicly available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor.

PPO NETWORK INFORMATION

This Plan has PPO and Non-PPO benefits. A PPO provider is a Network provider. A Non-PPO provider is a Non-Network provider. Certain benefits in this Plan (e.g. the deductible, coinsurance and out-of-pocket limits) vary between the PPO and Non-PPO providers. PPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the Plan’s incentives to use PPO providers. These contracts establish a fair market value for health care services, which in most cases will reduce Your costs.

Your Employer has contracted one or more PPOs to provide services to this Plan in the areas that it has Employees. Each PPO network consists of physicians, Hospitals and other medical care providers. The PPO that is applicable to You is shown on Your ID card.

PRIOR AUTHORIZATION REQUIREMENTS

UMR, Inc. will handle the authorization requirements of *your plan*. *You* should call UMR CARE (Care Management) for authorization as soon as possible to receive proper care coordination. However, *you* must call within the time frames shown below. The toll-free number is shown on the back of *your* ID card.

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Inpatient Hospitalization: • Inpatient maternity stays over 48 hours for normal delivery and 96 hours for a C-Section. • Inpatient Behavioral Health (acute care) • Transplants and transplant-related services • Skilled Nursing Facility (Extended Care Facilities) • Residential Treatment **Home Health Care** **Partial Hospitalization Program** **Durable Medical Equipment** (Excludes braces and orthotics): • $500 for rental • $1,500 for purchase • $1,000 for prosthetics **Clinical Trials** • Services related to the clinical trial **Bariatric Surgery** **Dialysis**	**Inpatient Admissions:** ***PPO***: No penalty (for the *covered person*). **Non-*PPO***: $500 per occurrence (excluding clinical trials) The penalty is taken prior to applying the deductible and coinsurance provisions of the *plan*. The penalty is not applied to the out-of-pocket limit. **Other Than Inpatient Admissions:** ***PPO* and Non-*PPO***: $500 per occurrence (excluding clinical trials) The penalty is taken prior to applying the deductible and coinsurance provisions of the *plan*. The penalty is not applied to the out-of-pocket limit.	**Inpatient Admissions** ***PPO***: ***Your PPO* provider** is required to notify UMR for authorization. ***Non-PPO***: ***You*** must call UMR for authorization in advance of any Non-Emergency inpatient admission. If admission is on an *emergency* basis, UMR must be notified as soon as medically possible. If You do not obtain authorization, benefits will be payable after the non-compliance penalty. **Other Than Inpatient Admissions:** ***PPO and Non-PPO***: ***You*** must call UMR for authorization. If You do not obtain authorization, benefits will be payable after the non-compliance penalty.	1-15

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF COVERAGE.

Schedule of Benefits – continued

MEDICAL BENEFITS

Plan *Lifetime* **Maximum:** Unlimited

MEDICAL BENEFITS (QHDHP/HSA Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year* *PPO* Individual Family Non-*PPO* Individual Family	 $0 $0 $0 $0	 $1,500 $4,000 $3,000 $8,000	The amount *you* must pay each year before the *plan* will begin paying any benefits. **Individual Coverage**: If *you* elected to cover only yourself, the Individual deductible will apply. The *plan* will not begin paying benefits until this deductible is met. **Family Coverage**: If *you* elected Family Coverage, the Family deductible will apply. The Family deductible applies in full to each *covered person* until it has been satisfied. It may be satisfied by one person or through a combination of family members. The *plan* will not begin paying benefits for any *covered person* until the Family deductible is met. The *PPO* and Non-*PPO* deductibles cross-satisfy one-another.	1-13
Individual Coinsurance per *Calendar Year* *PPO* Non-*PPO*	 100% 80%	 0% 20%	After the deductible, the coinsurance amounts shown apply. After which the *plan* pays 100% of *covered expenses* subject to any maximums.	1-13

MEDICAL BENEFITS (QHDHP/HSA Plan)	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Out-of-Pocket Limit per *Calendar Year* *PPO* Individual Family Non-*PPO* Individual Family Prescription Drug Out-of-Pocket Limit per *Calendar Year* (after *PPO* deductible is met) Individual Family **Note:** $6,550 *PPO* Individual Limit for Family Coverage		 $1,500 $4,000 $5,000 $12,000 $2,550 $9,100	Represents the total paid for the deductible, coinsurance and medical copays (if applicable). After which the *plan* pays 100% of *covered expenses* subject to any maximums. **Individual Coverage**: If *you* elected to cover only yourself, the Individual out-of-pocket limit will apply. The *plan* will not begin paying benefits until this out-of-pocket limit has been met. **Family Coverage**: If *you* elected Family Coverage, the Family out-of-pocket limit will apply. The Family out-of-pocket limit applies in full to each *covered person* until it has been satisfied. It may be satisfied by one person or through a combination of family members. The *plan* will not begin paying benefits for any *covered person* until the family out-of-pocket limit is met. The *PPO* and Non-*PPO* out-of-pocket limits cross-satisfy one-another. **Prescription Drugs**: Payable as shown in the Prescription Drug Card section of the Schedule of Benefits.	1-13

All Non-*PPO covered expenses* under the *plan* are payable at the *plan's reasonable reimbursement, the usual and customary chare, the negotiated rate,* or the fee schedule *value* of each service provided. In the case of a *PPO* provider, *covered expenses* are payable at the negotiated *PPO* discount rate for the service or procedure. The deductible and coinsurance limits shown above apply to all *covered expenses* unless stated otherwise below.

PPO Benefit Provision
Some benefits may be processed at the PPO benefit level when provided by a Non-*PPO* provider. The following exceptions may apply:

1. *PPO* benefits will be payable for a *covered expense* that is incurred for pathology, radiology, Certified Registered Nurse Anesthetist (CRNA) or anesthesiology services from a Non-*PPO* provider if *you* are referred to the Non-*PPO* provider by a PPO *qualified practitioner* or the services are performed at a *PPO* facility.

2. *Covered expenses* provided by a *qualified practitioner* during an *inpatient* stay will be payable at the *PPO* level of benefits when provided at a *PPO hospital*.

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-17
Qualified Practitioner Benefits	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Inpatient and outpatient *hospital* visits, home and office visits, surgery and anesthesia.	1-17
Oral Surgery Benefit	*PPO* deductible/ 100% to the *PPO* out-of-pocket limit (for *PPO* and Non-*PPO* providers)	Refer to list of covered oral surgeries in text.	1-18
Wellness Benefit	*PPO*: 100%, deductible and coinsurance waived Non-*PPO*: Deductible/80% to the out-of-pocket limit **Immunizations** *PPO*: 100%, deductible and coinsurance waived Non-*PPO*: Deductible/80% to the out-of-pocket limit **(<u>except</u>** for certain routine immunizations, as shown later in this Schedule of Benefits.)	Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, routine immunizations, routine mammograms, routine pap smears and pelvic exams, routine PSA tests and prostate exams, routine colon cancer screenings (e.g. colonoscopies) and treatment of nicotine/tobacco addiction. Refer to the Wellness Benefit section of the Plan for additional information. **Mammograms**: Limited to one routine per *calendar year*. (3D mammograms are covered.) **Pap Smears and Pelvic Exams**: Limited to one routine per *calendar year*. **PSA Tests and Prostate Exam**: Limited to one routine per *calendar year*.	1-18

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Outpatient Hospital Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit		1-20
Emergency Room Benefit	*PPO* deductible/ 100% to the *PPO* out-of-pocket limit (for *PPO* and Non-*PPO* providers)	This benefit includes *emergency* room physician charges and other services provided in the *emergency* room. *Emergency* room treatment is limited to *emergencies*, as defined in this *plan*.	1-20
Urgent Care Center Benefits	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all *covered expenses* performed during the visit.	1-20
Ambulatory Surgical Center	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Charges made by an *ambulatory surgical center* for use of the facility in performing a covered surgery and *hospital* miscellaneous services provided in the facility.	1-21
X-ray and Laboratory Tests	*PPO:* Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Dental x-rays limited to covered oral surgery or *injury*.	1-21

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Outpatient Advanced Imaging (PET/ CT/ MRI/ MRA and Nuclear Medicine)	*PPO:* Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit		1-21
Ambulance Service Benefit	*PPO* deductible/ 100% to the *PPO* out-of-pocket limit (for *PPO* and Non-*PPO* providers)	Limited to appropriate transport to the nearest facility equipped to treat the *sickness* or *injury*.	1-21
Pregnancy Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Covered for *employee*, *dependent* spouse and *dependent* daughter. Charges mandated by Health Care Reform for pre-natal care and screening for gestational diabetes are payable as shown under the Wellness Benefit. (This also applies to Dependent daughter maternity, even if the Plan does not cover Dependent daughter maternity. This does not apply to high risk pregnancy or complications of pregnancy). Pre-natal ultrasounds covered under X-ray and Lab Test Benefit.	1-21
Newborn Benefits	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	See "Section 3 – Eligibility" for important information on *Dependent* Coverage.	1-22
Birthing Center Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit		1-22

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Extended Care Facility Benefit	*PPO* deductible/ 100% to the PPO out-of-pocket limit (for PPO and Non-PPO)	Limited to 120 days per admission.	1-22
Home Health Care Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Limited to 40 visits per *calendar year*.	1-22
Hospice Care Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	*Hospice care* must be in lieu of a covered *confinement* in a *hospital* or *extended care facility*. Bereavement counseling: Must be furnished within 12 months of the hospice patient's death.	1-23
Human Organ and Tissue Transplants	PPO: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	**NOTE**: This coverage is only available if *you* have been denied coverage through the insured transplant program. A written denial from insured transplant program must be obtained. (Procurement benefits are limited to $10,000 paid per organ.) Refer to the Human Organ and Tissue Transplants section of the Plan for more information. **Insured Transplant Policy**: Benefits are not payable under this *plan* for transplants that are covered under the insured transplant policy. *You* are not entitled to double benefits under both the insured transplant policy and this *plan*.	1-24
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Paid the same as any other *sickness* or *injury*.		1-24

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Other Covered Expenses	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/100% to the out-of-pocket limit		1-28
Teladoc Services Benefit	Deductible/ 100% to coinsurance limit	Refer to the Teladoc Services Benefit section of the Plan for more information.	1-25
Chiropractic Services and Manipulations	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Billed by any *qualified practitioner* for the treatment of an *injury* or *sickness* Routine and maintenance care is not covered.	1-28
Physical, Speech and Occupational Therapy	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Maintenance therapy is not covered.	1-28
Cardiac Rehabilitation	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Limited to Phase I and Phase II only. Phase II: Limited to 48 visits per *calendar year*. Maintenance therapy is not covered.	1-28
Take-Home Medications	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit		1-29

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Allergy Injections, Serum and Testing	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit		1-29
Second Opinions	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Charges for a second opinion. Refer to Second Opinions in the list of Other Covered Expenses for more information.	1-29
Nutritional Counseling	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Nutritional counseling by a registered dietician or other Qualified Practitioner for a Covered Person who is diagnosed with morbid obesity, an eating disorder such as bulimia or anorexia nervosa, or any other diagnosed health condition. Limited to four visits per Calendar Year.	1-29
Enteral Feedings	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Enteral feeding and supplies, including feeding tubes, pumps, bags and products, provided the feedings are prescribed by a *qualified practitioner* and are the sole source of nutrition for the *covered person*. Infant formula administered through a tube as the sole source of nutrition for the *covered person* is not covered.	1-29
Routine Immunizations (in addition to the Wellness Benefit)	100%, deductible and coinsurance waived (for *PPO* and Non-*PPO*)	Limited to *dependent* children under six years of age. Refer to the list of covered immunizations in the Other Covered Expenses section of this *plan*. This benefit is in addition to any Wellness or Well Child Care benefit that may be part of this *plan*.	1-32

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
TMJ Benefit	*PPO* deductible/ 100% to the PPO out-of-pocket limit (for PPO and Non-PPO)	Benefits include surgical and non-surgical treatment.	1-32
Hearing Aids and Cochlear Implants	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	For Covered Persons under 18 years of age. Refer to Hearing Aids in the list of Other Covered Expenses for more information about the hearing aid benefits.	1-32
Dental (Hospital or Ambulatory Surgical Services)	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Applies to: 1) a child under the age of five years, 2) a person with a chronic disability, 3) a person with a *medical condition* that requires hospitalization for such dental care, or 4) a person with a *medical condition* that requires general anesthesia, for such dental care. Refer to the Other Covered Expenses section of this *plan* for details about this benefit.	1-33
Blood Lead Tests	If these tests are not covered under the Wellness Benefit, they will be paid the same as any other lab test	For covered *dependent* children under six years of age. According to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services.	1-33
Autism Benefit	*PPO*: Deductible/ 100% to the out-of-pocket limit Non-*PPO* Deductible/80% to the out-of-pocket limit	Refer to the Autism benefit in the list of Other Covered Expenses for more information about the autism benefits.	1-33

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Limitations and Exclusions	Not Payable	List of exclusions that apply to all *covered expenses*. A service that is normally covered or *medically necessary* may be excluded when provided with an excluded item.	1-36
Prescription Drug Card	*PPO* medical deducible, then copay/100% up to the Prescription Drug Out-of-Pocket Limit. **Preventive Drugs** Certain preventive prescription products and prescription contraceptives might be available at no cost to *you*.	The *PPO* medical deductible amount must be satisfied first. **Retail**: 34-day supply per fill. • Tier 1 Generic: $10 copay • Tier 2 Preferred Brand: $25 copay • Tier 3 Non-Preferred Brand: $40 copay **Home Delivery**: 90-day supply per fill. • Tier 1 Generic: $20 copay • Tier 2 Preferred Brand: $50 copay • Tier 3 Non-Preferred Brand: $80 copay **Specialty:** 30-day supply per fill. • Tier 1 Generic: $10 copay • Tier 2 Preferred Brand: $25 copay • Tier 3 Non-Preferred Brand: $40 copay **Prescription Drug Copay Out-of-Pocket Limit:** Individual: $2,550 per *calendar year*. Family: $9,100 per *calendar year*.	1-41

HOW TO FILE A MEDICAL CLAIM

You will receive a *plan* identification (ID) card. It will show *your* name and group number.

Provider bills should be sent to the address on *your* ID card. Bills can be sent on a standard government claim form. UMR, Inc. does not require special claim forms**.**

Be sure each bill shows the group number and participant number found on *your* ID card. The *covered person's* name (*employee* or *retiree*) and the patient's name should also be included on each bill.

MISCELLANEOUS MEDICAL CHARGES

Bills for medical items *you* purchased yourself should be sent to UMR, Inc. at least once every three months (quarterly). Make sure each receipt includes: the group number, participant number, *employee* name (or retiree name), patient name, name of prescribing *qualified practitioner* and date purchased.

PAYMENT OF CLAIMS

The *plan* will make direct payment to the service provider. If *you* have paid the bill, please indicate on the original bill "paid by *employee*" or "paid by retiree" and payment will be made to *you*. *You* will receive a written explanation of payment or reason for denial of any portion of a claim. The *plan* reserves the right to request any information required to determine benefits or process a claim. *You* or the service provider will be contacted if additional information is needed to process *your* claim.

CLAIM FILING LIMITS

You must provide the *plan* with written proof of *your* claim. Proof should be provided as soon as possible after the date the claim was incurred. *Your* claim will not be denied if it was not reasonably possible to give such proof. However, unless *you* were legally incapacitated during the period, any claim received by the *plan* more than 24 months after the date the claim was incurred will not be covered under the *plan*.

If the *plan* is terminated, written proof of any claims incurred prior to the termination must be given to the *plan* within 12 months of its termination. Any claim received by the *plan* more than 12 months after it is terminated will not be covered under the *plan*.

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the deductible, at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

Deductible

The deductible applies to each *covered person*, each *calendar year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

Maximum Family Deductible

The total deductible applied to all *covered persons* in one family, in a *calendar year*, is subject to the maximum shown on the Schedule of Benefits. Once *your* family reaches this maximum for a *calendar year*, no further deductibles will be applied during that *calendar year*.

Coinsurance

Benefits are payable at the percentage rate shown on the Schedule of Benefits, after the deductible is satisfied each *calendar year*. Benefits are payable for the rest of the *calendar year* or up to any *plan* maximums at the percentage rate shown on the Schedule of Benefits.

Out-of-Pocket Limit

The amount *you* must pay is the out-of-pocket limit. The out-of-pocket limit is shown on the Schedule of Benefits. The out-of-pocket limit is made up of the deductible, coinsurance and medical and prescription drug copays (if applicable). When the out-of-pocket limit has been met for a *covered person* or family, the *plan* will pay 100% of *covered expenses* for the rest of the *calendar year*. (If *you* use *PPO* and Non-*PPO* providers, *PPO covered expenses* will be applied to both out-of-pocket limits. *Your* out-of-pocket expense for a *calendar year* will not exceed the Non-*PPO* limit.) Any amounts over the *reasonable reimbursement, usual and customary amount, negotiated rate,* or established fee schedule that this Plan pays will not be used to meet the out-of-pocket maximums.

This limit does not apply to penalties for failure to comply with the Prior Authorization requirements.

TRANSITIONAL CARE

Certain *covered expenses* that would have been considered at the In-Network (*PPO*) benefit level by the prior claims administrator, but that are not considered at the In-Network (*PPO*) benefit level by the current *claims administrator*, may be paid at the applicable In-Network (*PPO*) benefit level if the *covered person* is currently under a treatment plan by a *qualified practitioner* who was a member of this *plan's* previous *PPO* Network but who is not a member of the *plan's* current *PPO* Network in the *employee's* or *dependent's* Network area. In order to ensure continuity of care for certain *medical conditions* already under treatment, the In-Network (*PPO*) medical *plan* benefit level may continue for 90 days for conditions approved as transitional care.

Examples of *medical conditions* appropriate for consideration for transitional care include, but are not limited to the following:

1. Cancer, if under active treatment with chemotherapy and/or radiation therapy;

2. Organ transplants for a *covered person* under active treatment (e.g., seeing a *qualified practitioner* on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant);

3. Being *inpatient* in a *hospital* on *your* effective date of coverage under this *plan*;

4. Post-acute *injury* or surgery within the past three months;

5. Pregnancy in the second or third trimester and up to eight weeks postpartum;

6. Behavioral health (any previous treatment).

You or *your dependent* must call UMR within 30 days prior to *your* effective date under this *plan* or within 30 days after *your* effective date under this *plan* to see if *you* or *your dependent* are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, treatment for minor *illnesses* and elective surgical procedures will not be covered by transitional level benefits.

PRIOR AUTHORIZATION

HOW THE PROGRAM WORKS

When *you* call UM for authorization, *you* will be asked the following questions:

1. Group name and number
2. Name of *employee*
3. *Employee's* participant #
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once Prior Authorization is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new Prior Authorization must be made if: *you* do not receive the treatment within 30 days of the scheduled date; *you* use a different facility or physician; or *you* are admitted for a different reason.

PRIOR AUTHORIZATION REQUIREMENTS

You or *your qualified practitioner* are required to notify UMR CARE (Care Management) for authorization prior to receiving certain types of health care. The services that require Prior Authorization are listed on the Schedule of Benefits. **If *you* are required to provide Prior Authorization and fail to do so, benefits may be reduced or denied.**

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS.

NON-COMPLIANCE PENALTY

If the provider is required to obtain Prior Authorization and it is not provided, *you* will not be subject to the non-compliance penalty. *Your* treatment will be reviewed when a claim is received.

If *you* are required to obtain Prior Authorization and it is not provided, *your* treatment will be reviewed when a claim is received. If it is determined to be a *covered expense*, benefits that are otherwise payable will be reduced as shown on the Schedule of Benefits under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken before subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket limit.

If *your* treatment is not a *covered expense*, no benefits will be payable under the *plan*.

PRIOR AUTHORIZATION FOR SECONDARY COVERAGE

If this *plan* is secondary to another medical plan that also covers *you*, ***prior authorization*** **will also be required for this *plan*.**

CASE MANAGEMENT

Case management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. Participants are identified using system-integrated, automated and manual trigger lists, including the *prior authorization* review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer referrals or self-referrals. UMR CARE (Care Management) works directly with the patient, the patient's family members, the treating physician and the facility to mobilize appropriate resources for the *covered person's* care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future.

Prior Authorization – continued

In addition to managing catastrophic and complex behavioral health and substance use disorders, UMR's specialized nurses provide support for identified members utilizing Inpatient/rehabilitation/residential facilities. Member identification is through specific behavioral health and substance use disorder diagnostic triggers with primary emphasis on opioid and alcohol dependence.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS

Charges made for the following services or supplies furnished by a *hospital* are payable as shown on the Schedule of Benefits.

Room and Board
Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of *confinement.* Benefits for a private or single-bed room are limited to the charge for a semi-private room in the *hospital,* unless necessary due to *your sickness* or *injury* or the *hospital* offers only private rooms for the services provided, such as birthing rooms.

Hospital Miscellaneous Charges
Charges made by the *hospital* on its own behalf for services and supplies furnished for *your* treatment during *confinement,* including the following charges made by a *qualified practitioner,* whether billed directly or separately by the *hospital*:

1. Professional services of a radiologist or pathologist for diagnostic x-ray and laboratory tests; and

2. Professional services of an anesthesiologist.

QUALIFIED PRACTITIONER BENEFITS

Benefits are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* for the following services:

1. *Qualified Practitioner* home and office visits;

2. Inpatient *hospital* visits by a *qualified practitioner*;

3. Outpatient medical services by a *qualified practitioner*;

4. Surgical services. A surgical procedure, including pre- and post-operative care and subsequent care for surgeries performed in the outpatient department of a *hospital* or *ambulatory surgical center*. Diagnostic x-ray and laboratory services related to a covered surgery are also a *covered expense* under this benefit.

   Subsequent surgical procedures (i.e. suture or cast removal) will only be considered for payment as a separate service when performed by a *qualified practitioner* other than the operating surgeon.

5. Assistant surgeon services. The services of a second surgeon or a licensed surgical assistant are a *covered expense* only when the services are necessary for the safe and effective performance of a covered surgical procedure;

6. Administration of anesthesia. Payable only if they are not included in the global surgical fee; and

7. Services provided by an anesthesiologist or anesthetist to monitor the *covered person's* vital signs.

ORAL SURGERY BENEFIT

Charges made for these oral surgeries are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays. *Hospital* or *ambulatory surgical center* services are also covered.

1. Excision of partially or completely impacted teeth;

2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams;

3. Surgical procedures to correct *accidental injuries* of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

4. Reduction of fractures and dislocations of the jaw;

5. External incision and drainage of cellulitis;

6. Incision of accessory sinuses, salivary glands or ducts;

7. Excision of exostosis of the jaws and hard palate;

8. Frenectomy (the cutting of the tissue in the midline of the tongue);

9. Gingival mucosal surgery (gingivectomy, osseous, periodontal surgery and grafting) to treat gingivitis or periodontitis);

10. Apicoectomy (the excision of the tooth root without the extraction of the entire tooth.)

11. Root canal therapy, if performed in conjunction with an apicoectomy;

12. Alveolectomy (leveling of structures supporting teeth for the purpose of fitting dentures). Not payable if performed in conjunction with routine extraction of natural teeth);

13. Treatment required to repair or restore natural teeth damaged due to *injury*. To be a *covered expense* under the *plan*, the repair expense must be incurred within 12 months from the date of the *injury*. Dental implants are covered for dental *injury*. Damage resulting from biting or chewing will not be considered an *injury*;

14. Dental implants. Covered only when required as the result of an *injury*; and

15. Extraction of seven or more natural teeth at one time.

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. *Covered expenses* include but are not limited to the following:

All Covered Persons

1. Preventive medicine visits (wellness exams);
2. All standard immunizations recommended by the American Committee on Immunization Practices. (Immunizations for foreign travel are covered. Shingle vaccines are limited to *covered persons* 60 years of age and older.)

Wellness Benefit – continued

3. Treatment of nicotine addiction, including counseling and services required to obtain a prescription for smoking cessation drugs. (The Medical Plan does not cover the drugs. They might be covered under the Prescription Drug Card.)

Screening/Services For All Covered Persons

1. Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy, CT colonography);
2. Elevated cholesterol and lipids;
3. Certain sexually transmitted diseases and HIV (includes counseling);
4. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
5. High blood pressure;
6. Diabetes;
7. Depression;
8. Screening/counseling for obesity (adults and children).

For Women

1. Routine mammograms. Limited to one routine mammogram per *calendar year*. 3D mammograms are covered.
2. Routine pap smears and pelvic exams. Limited to one routine per *calendar year*.
3. Counseling for genetic testing for BRCA breast cancer gene;
4. Screening for gonorrhea, chlamydia, syphilis;
5. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;
6. Instructions to promote and help with breast feeding;
7. Screening for osteoporosis;
8. Counseling for those at high risk for breast cancer for chemoprevention;
9. Gynecological exams;
10. Routine pre-natal care;
11. Routine gestational diabetes screening;
12. Human papillomavirus (HPV) DNA testing for all covered women;
13. Counseling for sexually transmitted infections (provided annually);
14. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
15. Breastfeeding support, supplies and counseling in conjunction with each birth. Benefits include comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and charges for the rental or purchase of breastfeeding equipment (breast pumps and related supplies). Benefits for breast pumps include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth;
16. Screening and counseling for interpersonal and domestic violence (provided annually);
17. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), such as insertable vaginal devices, injections and administration, devices (e.g. IUD, implants) including insertion and removal, sterilizations (for any covered female person), patient education and related office services.

    Note: Contraceptive patches, oral tablets and self-insertable vaginal devices containing contraceptives hormones (ie: Nuva ring) are covered under the Prescription Drug Card.)

    a. ***PPO*/In-Network**: Payable under Wellness/Routine Benefit.
    b. **Non-*PPO*/Out-of-Network**: Paid as any other *sickness* or *injury*.

    If the services are billed with a diagnosis other than contraceptive management, the *covered expenses* will be considered under the *sickness/injury* benefits, rather than the Wellness Benefit.)

Wellness Benefit – continued

For Men

1. PSA tests and prostate exams. Limited to one routine *calendar year;*
2. Screening for abdominal aortic aneurysm;
3. Human papillomavirus (HPV) DNA testing;
4. Counseling for sexually transmitted infections (provided annually);
5. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);
6. Screening and counseling for interpersonal and domestic violence (provided annually).

For Children

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for developmental delay/autism;
5. Screening for lead and tuberculosis. (Note: Blood lead tests that are not covered under this benefit are payable as shown in the Other Covered Expenses section of this *plan*.)
6. Preventive/routine oral fluoride supplements prescribed for *dependent* children ages six months to five years if their primary water source is deficient in fluoride;
7. Vision screenings for dependent *children* under five years of age.

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/

OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient *hospital* services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of *your sickness* or *injury*;

2. Diagnostic x-rays and laboratory services;

3. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by *your* attending *qualified practitioner*; and

4. *Emergency* room charges, but **only** if incurred due to:

    a. *Emergency accident* treatment,
    b. a surgical procedure, or
    c. treatment of a *sickness* that is a medical *emergency*.

URGENT CARE CENTER BENEFIT

Charges for *covered expenses* provided by an *Urgent Care Center* are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by a free-standing surgical facility or an *ambulatory surgical center* for use of the facility in performing a covered surgery are payable as shown on the Schedule of Benefits. *Hospital* miscellaneous services provided in the facility are also covered.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A *qualified practitioner* must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered *injury* or oral surgery.

AMBULANCE SERVICE BENEFIT

Charges for ground ambulance service to a local *hospital* are payable as shown on the Schedule of Benefits. If *you* need care that is not available in a local *hospital*, transport to the nearest *hospital* that can provide the care is covered. If *you* require care that is not available by ground ambulance, air ambulance service to the nearest *hospital* that can provide the care is covered.

PREGNANCY BENEFIT

Pregnancy is a *covered expense* for any covered female person and payable as shown on the Schedule of Benefits. *Complications of Pregnancy* are payable, for any covered female person, as any other covered *sickness* at the point the complication sets in.

Hospital and *qualified practitioner* services in performing elective and therapeutic abortions are *covered expenses*. Complications of abortions are payable for any covered female person at the point the complication sets in.

Outpatient birthing centers are covered. Scheduled home deliveries are covered if they are under the supervision of a *qualified practitioner*.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., *your* physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce *your* out-of-pocket costs, *you* may be required to obtain *prior authorization.* For information on *prior authorization*, contact *your plan administrator*.

Amniocentesis or ultrasounds performed solely to determine the gender of the fetus or those that are not *medically necessary* are not covered.

NEWBORN BENEFITS

A newborn child of a *covered person* is covered during the first 60 days of life. *Dependent* coverage **must** be in force for coverage to continue past the first 60 days of life. If *you* do not enroll *your* newborn *dependent* within 60 days of the date of birth, the child's coverage will terminate at the end of the 60 days.

See the "Eligibility" section of this booklet for more information.

Well-Newborn

Charges for these services for a well-newborn are payable as shown on the Schedule of Benefits: *hospital* nursery services; circumcision of a male child; routine examination of the newborn child before release from the *hospital*.

Sick-Newborn

Charges for these services for a sick-newborn are payable as shown on the Schedule of Benefits: treatment of *injury* or *sickness*; care and treatment for premature birth; treatment of medically diagnosed birth defects and abnormalities; and surgery to repair or restore normal body functioning. *Covered expenses* do **not** include plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to *injury*, infection or other disease of the involved part; or

2. Congenital disease or anomaly that resulted in a functional defect.

BIRTHING CENTER BENEFIT

Services and supplies provided in a *Birthing Center* for prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

EXTENDED CARE FACILITY BENEFIT

Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility.

HOME HEALTH CARE BENEFIT

Home health care services are provided when determined to be *medically necessary*.

Covered expenses may include:

1. Home visits, instead of visits to the *qualified practitioner's* office that do not exceed the maximum allowable under this *plan*;
2. Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period;
3. Nutrition counseling provided by or under the supervision of a qualified dietician, or other *qualified practitioner*, if applicable;
4. Physical, occupational, respiratory and speech therapy provided by or under the supervision of a qualified therapist, or *qualified practitioner*, if applicable; and
5. Medical supplies, drugs, laboratory services and medication prescribed by a *qualified practitioner.*

A *home health care* visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if *medically necessary*) or a single visit by a qualified therapist, qualified dietician, or other *qualified practitioner*, if applicable.

Home Health Care Benefit – continued

Exclusions

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

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

HOSPICE CARE BENEFIT

Charges for these *hospice care* services are payable as shown on the Schedule of Benefits. H*ospice care* must be in lieu of a covered *hospital* or *extended care facility confinement*.

1. Room and board;

2. Part-time nursing care by or supervised by a registered nurse (R.N.);

3. Counseling by a licensed clinical social worker. Counseling by a pastoral counselor. Benefits are provided for the hospice patient and immediate family;

4. Bereavement counseling by a licensed clinical social worker. Bereavement counseling by a pastoral counselor. Bereavement services must be furnished within 12 months of the hospice patient's death;

5. Medical social services provided to *you* or *your* immediate family. Services include:

    a. assessment of social, emotional and medical needs, and the home and family situation, and
    b. identification of the community resources available and assisting in obtaining those resources;

6. Dietary counseling;

7. Consultation and case management services;

8. Physical or occupational therapy;

9. Part-time home health aide service; and

10. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Limitations

Hospice care must be furnished in a *hospice facility* or by a *hospice care agency* in *your* home. A *qualified practitioner* must certify that *you* are terminally ill with a life expectancy of six months or less. For *hospice care* only, *your* immediate family is *your* parent, spouse and *dependent* children.

Hospice care benefits do **not** include: private or special nursing services; a *confinement* not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice Care Benefit – continued

Hospice care benefits do **not** include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; services by a licensed pastoral counselor to a member of his congregation; or respite care.

HUMAN ORGAN AND TISSUE TRANSPLANTS

This Plan provides benefits for human organ and tissue transplantation through Optum. Benefits under this plan are fully explained in the Optum transplant policy. Human organ or tissue transplant services for eligible Employees are covered under this separate policy, according to its terms and conditions. Transplant claims will be paid by Optum as described in the insurance policy.

Any charge that is covered, in whole or in part, under this insurance policy will not be considered a covered benefit under this SPD. Any health care services received at any time that are not related to the transplant, as well as transplant-related health services received before or after the benefit period, will be covered under the terms and conditions of this SPD.

Benefits offered for human organ and tissue transplants are subject to the following conditions:

- Eligibility - The Employee and any Dependent(s) are also subject to the eligibility terms under the Optum transplant policy.

- Policy terms - The Employee and any Dependent(s) must meet all the terms and conditions stated in the Optum policy, and are also subject to the policy's limitations.

PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

The following expenses incurred by *you* during a plan of treatment for a psychological disorder, chemical dependence or alcoholism are payable as stated below:

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital;* and

3. Charges made by a *qualified treatment facility*.

Inpatient Benefits

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown on the Schedule of Benefits.

Transitional Treatment Benefits

Covered expenses for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs: adult day treatment programs; child and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services provided by a residential treatment program; and services provided in a day treatment program.

Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits

Covered expenses for outpatient treatment received while not *confined* in a *hospital* or *qualified treatment facility* are payable as shown on the Schedule of Benefits.

Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

Limitations

Benefits do **not** include:

1. Treatment of nicotine habit or nicotine addiction. (Note: Certain services may be covered as specifically shown under the Wellness Benefit section of the Plan.)

2. Marriage counseling or family counseling; or

3. Court ordered examinations or counseling.

TELADOC SERVICES BENEFIT

Medical

Note: Teladoc Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses. This benefit does not apply to Covered Persons who have Medicare coverage.

Teladoc may be used:

1. When immediate care is needed.
2. When considering the ER or urgent care center for non-Emergency issues.
3. When *you* are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

1. General medicine, including, but not limited to:
   a. Colds and flu
   b. Allergies
   c. Bronchitis
   d. Pink eye
   e. Upper respiratory infections

Teladoc Services – continued

2. A refill of a recurring Prescription.
3. Pediatric care.
4. Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc does not guarantee that every consultation will result in a prescription. Medications are prescribed at the doctor's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after his or her consultation to call Teladoc with any clarification questions. A member of the Teladoc clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another Physician consultation for the same condition within 72 hours after the consultation call, he or she will be charged the Teladoc consultation fee.

Teladoc may not be used for:

1. Drug Enforcement Agency-(DEA) controlled Prescriptions.
2. Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc.
3. Consultations in states/jurisdictions where not available due to regulations or interpretations affecting the practice of telemedicine for medical or dermatology conditions.

Dermatology Services Program

In addition to receiving care for general medical conditions, Covered Persons may receive access to dermatology services, as described below.

Dermatologists provide dermatology consultations to Covered Persons through an online message center using store-and-forward technology in the dermatology service area. The dermatology program offers Covered Persons the ability to upload photographs of their dermatological conditions to licensed dermatologists, who provide treatment and prescription medication, when appropriate. The dermatologists are selected and engaged to provide dermatological assessments in accordance with standard dermatology protocols and guidelines that are tailored to the telehealth industry.

In order to receive dermatology consultations, the Covered Person must have completed Teladoc's requirement for access to the general medicine program, including the medical history disclosure form. The Covered Person must also complete a comprehensive Dermatology Intake Form prior to receiving a dermatology consultation. The Dermatology Intake Form consists of a Dermatology History section and an intake form for the condition for which the Covered Person is seeking treatment describing the area of concern. This medical history and intake form may be completed either online or by telephone with a designated dermatology representative. Additionally, the Covered Person must upload at least three images of his or her condition prior to communicating with a dermatologist. If the Covered Person fails to complete the Dermatology Intake Form or upload the required number of images, the Covered Person will not have access to the dermatologists.

Teladoc Services – continued

Covered Persons will be allowed to request more than one dermatology consultation at any given time. Dermatology consultations are not intended to be provided in Emergency situations.

Initial Consultation: The Covered Person will be required to upload a minimum of three images and a maximum of five images for the dermatologist to review. A dermatologist will respond to the Covered Person's consultation submission via the Teladoc Message Center within two business days of such submission. The dermatologist will either:

- determine that no additional information is required and provide a diagnosis and prescription, if appropriate; or
- request additional information from the Covered Person before making a diagnosis.

Covered Person Follow-Up: The Covered Person will have seven days after diagnosis to respond to the dermatologist with follow-up questions via the message center. The Covered Person will be able to respond only once and may upload up to five additional images in the response. The Covered Person will not be charged for a one-time follow-up.

Subsequent Consultations: A Covered Person will have the option of selecting the same dermatologist with whom he or she had a prior consultation or with a new dermatologist licensed in his or her state.

KIDNEY RESOURCE SERVICES (KRS)

Kidney Resource Services (KRS) provides access to a preferred provider dialysis network and support from UMR Case Management by collaborating with the Covered Person to delay the progression of the disease to renal failure.

UMR Case Management End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

If a Covered Person chooses to seek services at a KRS preferred provider, the Covered Person must contact UMR Case Management at 866-494-4502.

OTHER COVERED EXPENSES

These other *covered expenses* are payable as shown on the Schedule of Benefits:

1. Chiropractic care billed by any *qualified practitioner* for the treatment of an *injury* or *sickness.* Manipulations billed by any *qualified practitioner* for the treatment of an *injury* or *sickness*. Routine or maintenance care is not covered.

2. Treatment by a licensed: physical therapist; speech therapist; or occupational therapist. All treatment must be to restore loss or correct impairment due to an *injury* or *sickness*, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders. Maintenance therapy is not covered.

3. Cardiac rehabilitation following a recent cardiac event. Limited to Phase I (Inpatient) and Phase II (*qualified practitioner*-supervised outpatient) only. Subject to the limits shown on the Schedule of Benefits. Maintenance therapy is not covered.

4. Radiation therapy and chemotherapy.

5. Blood and blood plasma.

6. Prosthetic devices to replace lost natural limbs and eyes. Includes initial purchase, fitting, repairs and replacements. Repairs and replacements are covered, unless due to abuse or misuse of the device, as determined by the *plan*. Routine maintenance expenses are not covered. Dental appliances are not covered. Devices with special features are not covered.

7. Special supplies when prescribed by *your* attending *qualified practitioner* and necessary for the continuing treatment of a *sickness* or *injury*, unless they are payable under the Prescription Drug Program:

   a. catheters,
   b. colostomy bags, belts and rings,
   c. flotation pads,
   d. needles and syringes,
   e. casts, splints, surgical dressings, trusses, braces and crutches,
   f. custom molded orthotic devices. (Over-the-counter orthotics are not covered.),
   g. elastic stockings,
   h. oxygen and other gases,
   i. initial contact lenses or eyeglasses following for aphakia, keratoconus or following cataract surgery.

   Not Covered: Equipment or supplies that are used solely to facilitate participation in physical activity or sports.

8. Rental of durable medical equipment or purchase of such equipment when approved by the *plan* (e.g. wheelchair, *hospital* bed). The equipment must be needed for therapeutic treatment and not be mainly hygienic, custodial or educational in nature. It must be able to withstand repeated use. It must be primarily and normally used to serve a medical purpose. It must not be generally useful to a person except for the treatment of an *injury* or *sickness*. Repairs are covered if they are not required due to misuse of the equipment. Replacement devices are covered, unless required due to negligence or abuse of the device. Replacement batteries are not covered. Maintenance expenses are not covered. Convenience items, as determined by the *plan*, are not covered. Unless approved by the *plan* benefits for the rental of durable medical equipment will not exceed the cost to purchase the item. (Sales tax for durable medical equipment is covered.)

   The Plan does not cover motor vehicles; lifts for wheelchairs and scooters; stair lift or durable medical equipment that has special features.

Other Covered Expenses – continued

9. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).

10. Installation and use of an insulin infusion pump. The pump must be in use for 30 days before purchase. Other equipment used in the treatment of diabetes (i.e. blood glucose testing monitor). Diabetic self-management education programs and diabetic counseling are covered. Diabetic supplies and insulin are not covered under the medical plan. They might be covered under the prescription drug program.

11. Take home supplies and medications dispensed by the *hospital* at the time of *hospital* discharge for use at home. This includes discharge from the *emergency* room or an *urgent care center*.

12. Augmentation communication devices and related instructions or therapy.

13. Allergy testing, treatment and injections, if it meets the standards of the American Academy of Allergy, Asthma and Immunology (AAAAI). *Covered expenses* include initial diagnostic evaluations, diagnostic tests to determine the cause of an allergy, and injections of antigens (immunotherapy) to build up immunities, if warranted by the diagnosis. Food allergy testing is covered, but not therapy. Sublingual antigen drops are payable as any other Sickness or Injury.

14. Pre-admission testing. Testing required in connection with *your* surgery or a scheduled inpatient *hospital* admission. The tests must be approved by the *hospital* and the *qualified practitioner*. The tests may be performed in either a *qualified practitioner's* office or the *outpatient* department of a *hospital*.

15. Second opinions. Charges incurred for a second opinion. *You* may go to a *qualified practitioner* of *your* choice. Generally, the *qualified practitioner* may not be in practice with the practitioner who gave the initial opinion and may not perform the procedure.

16. Infertility testing. Diagnostic treatment is a *covered expense*. Diagnostic infertility tests for determination of the underlying condition and treatment of the *medical condition* if it is causing the infertility problem, including corrective surgery, are *covered expenses*. (Once the initial diagnosis of infertility is determined, no additional infertility testing will be covered.)

17. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), including sterilizations and patient education <u>for men</u>. (Services for women are payable as shown under the Wellness Benefit section of this *plan*.)

18. Breast reductions. When *medically necessary*.

19. Nutritional counseling and educational therapy by a registered dietician or other Qualified Practitioner for a Covered Person who is diagnosed with morbid obesity, an eating disorder, such as bulimia or anorexia nervosa or any other diagnosed health condition. Limited to four visits per *calendar year*. (Refer to the morbid obesity benefit in this plan for more information.)

20. Enteral feeding and supplies including feeding tubes, pumps, bags and products are covered, provided the feedings are prescribed by a *qualified practitioner* and are the sole source of nutrition for the *covered person*. (Infant formula administered through a tube as the sole source of nutrition for the *covered person* is not covered.

21. Sleep disorders, if *medically necessary*.

22. Sleep studies.

Other Covered Expenses – continued

23. Reconstructive surgery to treat an *injury*, *sickness*, infection or other disease of the involved part when the need for such surgery is not the result of or a complication of a prior cosmetic procedure. Reconstructive surgery to treatment a congenital disease or anomaly that causes a functional physical impairment.

24. Treatment of morbid obesity. Morbid obesity means a body mass index (BMI) that is greater than or equal to 40 kg/m2. If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by obesity not controlled despite maximum medical therapy and patient compliance with medical treatment plan, a BMI greater than or equal to 35 kg/m2 is applied. Morbid Obesity for a *covered person* who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

    Covered expenses include weight loss programs at a medical facility and supervised by a *qualified practitioner*, diagnostic services, nutritional counseling by a registered dietician or *qualified practitioner* (limited to four visits per *calendar year*) and bariatric surgery (e.g. gastric or intestinal bypass, stomach stapling, lap band and gastric sleeve procedure). The morbid obesity surgical consultation visit will be covered even if the surgery itself is not approved as a *covered expense*.

25. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:

    a. reconstruction of the breast that was removed,
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
    c. prostheses to replace the breast that was removed, and
    d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

    Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the *plan*.

26. Qualifying clinical trials as defined below, including routine patient care costs as defined below 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:

    1. Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;

    2. 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

    3. Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Other Covered Expenses – continued

Routine costs for clinical trials do not include:

1. The experimental or investigational service or item as it is typically provided to the patient through the clinical trial;

2. 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;

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and

4. 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.

1. 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:

    a. *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);

    b. *Centers for Disease Control and Prevention* (CDC);

    c. *Agency for Healthcare Research and Quality* (AHRQ);

    d. *Centers for Medicare and Medicaid Services* (CMS);

    e. A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the Veteran's Administration (VA);

    f. A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or

    g. The *Department of Veterans Affairs*, the *Department of Defense*, 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 *National Institutes of Health*; and

        – It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;

Other Covered Expenses – continued

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;

4. 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

5. 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.

27. Immunizations for any covered *dependent* child from birth to the age of six years are payable as shown on the Schedule of Benefits. This benefit is in addition to any Wellness or Well Child Care Benefit that may be part of this Plan. Including, but not limited to, the following immunizations:

    a. Diphtheria,
    b. Pertussis,
    c. Tetanus,
    d. Polio,
    e. Measles,
    f. Mumps,
    g. Rubella,
    h. Hemophilus influenza B,
    i. Hepatitis B.,
    j. Varicella.

28. Temporomandibular joint (TMJ) diagnostic, surgical and non-surgical treatment. Benefits include appliances and therapy for any jaw joint problem. Jaw joint problems include: temporomandibular joint disorder; craniomaxillary or craniomandibular disorder; other conditions of the joint linking the jaw bone and skull; treatment of the facial muscles used in expression or mastication functions; or symptoms thereof. Elective orthodontic treatment or services are not covered. Periodontal treatment is not covered. General dental care is not covered.

29. Hearing aids, cochlear implants and related treatment for a covered *dependent* child from birth through age 17 years of age, if the child is certified as deaf or hearing impaired by a *qualified practitioner* or audiologist. No coverage for ages 18 and older. *Covered expenses* include:

    a. the cost of hearing aids and cochlear implants that are prescribed by a *qualified practitioner* or audiologist, in accordance with accepted professional medical or audiological standards,
    b. the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices,
    c. One hearing aid per ear every three *calendar years*.

This *plan* includes a benefit that allows *covered persons* to access discounted hearing aids and related testing and fitting. This benefit is being offered under the *plan* by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, *you* will decide if *you* would like to have *your* hearing aids fitted in person with *your* hearing provider or to have *your* hearing aids delivered directly to *your* home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If *you* choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. *You* will be fitted with the hearing aid(s) by the local provider. If *you* choose home delivery, the hearing aids will be sent directly to *your* home within 5-10 business days from the order date.

  In the event that *you* have questions or complaints about the hearing aid products or services offered under the *plan*, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

30. Services of a *hospital* or *ambulatory surgical center* due to dental care. Anesthetics related to the dental care will also be covered. To be a *covered expense* the services must be provided to:

    a. a child under the age of five years,
    b. a person with a chronic disability,
    c. a person with a *medical condition* that requires hospitalization for such dental care, or
    d. a person with a *medical condition* that requires general anesthesia, for such dental care.

31. Blood lead tests for covered *dependent* children under the age of six years, if such tests are not covered under the Wellness Benefit. Payable as shown on the Schedule of Benefits. Testing will be covered according to recommended lead screening methods and intervals set by the rules of the Department of Health & Social Services.

32. Treatment of Autism Spectrum Disorders, including Autism disorder, Asperger's Syndrome and pervasive development disorder not otherwise specified. Treatment includes intensive-level services and non-intensive-level services. Subject to the requirements of the Wisconsin statutes.

    Intensive-level services means evidence-based behavioral therapies that are designed to help a *covered person* with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

    Non-intensive-level services means evidence-based therapy that occurs after the completion of treatment for intensive-level services or, for a *covered person* who has not and will not receive intensive-level services, evidence-based therapy that will improve the *covered person's* condition.

    Intensive-Level Services

    Benefits are provided for evidence-based behavioral intensive-level therapy for a *covered person* with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the *covered person* when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

Other Covered Expenses - continued

a. Based upon a treatment plan developed by a *qualified practitioner* that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the *covered person* be present and engaged in the intervention,

b. Implemented by *qualified practitioners*, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals,

c. Provided in an environment most conducive to achieving the goals of the *covered person's* treatment plan,

d. Included training and consultation, participation in team meetings and active involvement of the *covered person's* family and treatment team for implementation of the therapeutic goals developed by the team,

e. Commenced after a *covered person* is two years of age and before nine years of age,

f. The *covered person* is directly observed by the *qualified practitioner* at least once every two months.

Intensive-level services will be covered for up to four cumulative years. Any previous intensive-level services received by the *covered person*, regardless of payor, may be applied to the required four years.

The *plan* may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the *covered person* received for autism spectrum disorders prior to age nine.

Travel time for *qualified practitioners*, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week.

The *plan* requires that progress be assessed and documented throughout the course of treatment. The *plan* may request and review the *covered person's* treatment plan and the summary of progress on a periodic basis.

Non-Intensive Level Services

Non-intensive Level Services will be covered for a *covered person* with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to a *covered person* by a *qualified practitioner*, professional, therapist or paraprofessional in either of the following conditions:

a. After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment,

b. To a *covered person* who has not and will not receive intensive-level services but for whom non-intensive level services will improve the *covered person's* condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

Based upon a treatment plan developed by a *qualified practitioner*, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and

Other Covered Expenses – continued

a. continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the *covered person* be present and engaged in the intervention,
b. Implemented by *qualified practitioners*, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessional,

c. Provided in an environment most conducive to achieving the goal of the *covered person's* treatment plan,

d. Included training and consultation, participation in team meetings and active involvement of the *covered person's* family in order to implement the therapeutic goals developed by the team,

e. Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Non-intensive level services may include direct or consultative services when provided by *qualified practitioners*, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists.

The *plan* requires that progress be assessed and documented throughout the course of treatment. The *plan* may request and review the *covered person's* treatment plan and the summary of progress on a periodic basis.

Travel time for *qualified practitioners*, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week.

The *plan* will notify the *covered person* (or their authorized representative) if the level of treatment is transitioning from intensive-level services to non-intensive-level services. The notice will indicate the reason for the transition that may include any of the following:

a. The maximum four-year limit has been met,

b. Intensive-level services are no longer supported by the documentation provided by the *qualified practitioner*,

c. The *covered person* no longer receives at least 20 hours per week of evidence-based behavioral therapy over a six-month period.

Intensive-level and non-intensive-level services include, but are not limited to speech, occupational and behavioral therapies.

<u>The following services are not covered under the autism spectrum disorders</u>:

a. Acupuncture,
b. Animal-based therapy, including hippotherapy,
c. Auditory integration training,
d. Chelation therapy,
e. Child care fees,
f. Cranial sacral therapy,
g. Custodial or respite care,
h. Hyperbaric oxygen therapy,
i. Special diets or supplements,
j. Pharmaceuticals and durable medical equipment.

MEDICAL LIMITATIONS AND EXCLUSIONS

This *plan* does **not** provide benefits for:

ALTERNATIVE TREATMENTS

1. Any charge for **alternative medical treatments**. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, massage therapy, herbal therapy, vitamin therapy or hypnosis; or

2. **Acupuncture; acupressure**.

DENTAL

1. **Dental care** or treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as stated;

2. **Orthognathic, Prognathic, and Maxillofacial** surgery unless required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment; or

3. **Dental implantology** techniques, including prosthetic devices related to such techniques, unless shown as covered under the Oral Surgery Benefit.

DRUGS, SUPPLEMENTS

1. Charges for **prescription drugs**, unless they are not covered by the *employer's* Prescription Drug Card and not excluded under any other provision of this *plan*;

2. **Growth hormones**;

3. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a** *qualified practitioner* **(OTC - over the counter)**, except as shown under the Other Covered Expenses section of the Plan. Supplemental feedings, over-the-counter nutritional and electrolyte supplements. OTC items specifically stated in this plan as a *covered expense* will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a *qualified practitioner's* office, *hospital* or other facility it will be covered; or

4. Infant formula administered through a tube as the sole source of nutrition for the *covered person.* (Enteral feedings for other *covered persons* are payable as shown on the Schedule of Benefits.)

EXPERIMENTAL OR UNPROVEN SERVICES

1. Experimental, investigational or unproven services, which means any drug, service, supply, care and/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:

a. 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. (This exclusion does not apply to investigational new drugs which have reached a Phase 3 clinical testing for the treatment of HIV infection.)

b. items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet 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;

c. items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

d. items which 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 and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/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 OncologyTM 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.

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to *injury*, infection or other disease of the involved part is a *covered expense* when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;

2. Any charges for, relating to or resulting from **sex change operations**;

3. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;

4. Any treatment or services for **weight control or reduction,** except as specifically stated for preventive counseling**.** Treatment includes, but is not limited to: nutritional supplements; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs; health club memberships. (Nutritional counseling by a registered dietician or other Qualified Practitioner is a *covered expense,* as shown under the Other Covered Expenses.)

5. Any treatment of **obesity**, including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy). (**Note**: Treatment of morbid obesity is payable as shown under the Other Covered Expenses.)

6. **Wigs** or artificial hairpieces or similar items for replacement of hair;

7. Panniculectomy, unless determined by the *plan* to be *medically necessary*; or.

8. Abdominoplasty.

PROVIDERS

1. Any service or supply:

   a. provided while *you* are **not under the regular care of a** *qualified practitioner*,
   b. **not authorized or prescribed by a** *qualified practitioner*,
   c. authorized or prescribed by a *qualified practitioner*, but **excluded under this** *plan*;

2. Services provided by a **person who ordinarily resides in** *your* **home** or who is a *family member*;

3. **Telephone, computer or Internet consultations** between *you* and any provider. Completion of claim forms or forms necessary for *your* return to work or school. Any appointment *you* did not attend;

4. **Private duty nursing** while in a *hospital* or other *qualified treatment facility*. (**Note**: Outpatient private duty nursing is a *covered expense*.) or

5. **Taxes.** Sales tax, shipping and handling charges, unless covered elsewhere in this Plan. (Sales tax for durable medical equipment is covered.)

REPRODUCTION

1. Any **artificial means to achieve pregnancy** including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment, and drugs. (**Note**: Diagnostic testing up to the original diagnosis of infertility is a *covered expense*. Diagnostic infertility tests for determination of the underlying condition and treatment of the *medical condition* if it is causing the infertility problem, including corrective surgery are *covered expenses.* Once the initial diagnosis of infertility is determined, no additional infertility testing will be covered.)

2. Treatment of a **sexual dysfunction**, including, but not limited to diagnostic services, surgical treatment, non-surgical treatment, sexual counseling or therapy, implants, hormonal therapy and prescription drugs;

3. **Genetic testing or counseling**, unless specifically stated otherwise as a *covered expense*; genetic counseling or testing based on family history. (Genetic counseling or testing based on *medical necessity* is covered.)

4. The **reversal of voluntary sterilization** procedures; or

5. **Amniocentesis and ultrasounds** that are not *medically necessary*.

ROUTINE AND GENERAL HEALTH

1. **Routine vision exams and related refractive charge; vision therapy** (orthoptics), corneal refractive therapy, radial keratotomy or keratoplasty to correct refractive disorders, **eyeglasses, contact lenses** or the examination for, fitting or repair of eyeglasses. The initial purchase of eyeglasses or contact lenses for aphakia, keratoconus and after a cataract surgery is a *covered expense* as shown under the Other Covered Expenses.

Medical Limitations and Exclusions – continued

2. **Routine hearing exams**. (**Note**: Certain hearing aids, cochlear implants and related treatment are payable as shown on the Schedule of Benefits and under the Other Covered Expenses section of this Plan.)

3. **Third party exams/court-ordered**, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for school, occupation, employment, travel or the purchase of insurance; unless specifically stated as a *covered expense* or as required by the Affordable Care Act (ACA);

4. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction, except as shown under the Wellness Benefit; or

5. **Maintenance therapy**.

SERVICES UNDER ANOTHER PLAN

1. Any *injury* or *sickness* arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers' Compensation** or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

2. Any service or supply for which **no charge is made**, or for which *you* would not be required to pay if *you* did not have this coverage;

3. Any charges that **would have been paid by** *your* **primary plan** had *you* complied with all of the pre-certification requirements of that plan;

4. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include *Medicare* or Medicaid);

5. Any service or supply provided in the care of any service related *injury* or *sickness* (past or present) **if** *you* **are in a** *hospital* **or facility owned or operated by the United States Government** or any of its agencies; or

6. Organ and tissue transplants that are **covered under the insured transplant policy**. (*You* are not entitled to double benefits under both the insured transplant policy and this *plan.*)

OTHER

1. Excess charges or the portion thereof that are in excess of the *reasonable reimbursement, the usual and customary charge, the negotiated rate*, or the fee;

2. Services **not *medically necessary*** for diagnosis and treatment of an *injury* or *sickness*;

3. *Custodial care*; rest cures;

4. Any medical expense incurred **before *your* effective date** of coverage under this *plan* or **after the date** *your* **coverage under the** *plan* **terminates**, except as specifically described;

5. Charges incurred **outside the United States** if *you* traveled to such location to obtain the service, drug or supply. (If *you* are traveling on vacation, *covered expenses* due to *sickness* or *injury* are payable under the Plan.)

Medical Limitations and Exclusions – continued

6. **Charges for travel,** except as stated under the Ambulance Service Benefit; **charges for lodging**;

7. Any medical expense due to commission or attempt to commit a **civil or criminal battery or felony** except if due to domestic violence;

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

9. **Educational testing or training or recreational therapy**; special education for the learning disabled. This exclusion does not apply to *medically necessary* therapy;

10. Services or treatment for **learning disabilities, developmental delays**, or other *medical condition*s that do not constitute a distinct medical diagnosis, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders; **habilitative services**, except as specifically stated otherwise for the treatment of Autism Spectrum Disorders;

11. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;

12. **Convenience items.** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays; any treatment that is a **common household item**, such as air conditioners, humidifiers and exercise equipment, whether or not recommended by a *qualified practitioner*;

13. **Routine foot care**, unless related to a medical diagnosis, such as, but not limited to diabetes, peripheral neuropathies or arteriosclerosis, or as specifically stated under the Other Covered Expenses. Routine foot care includes, but is not limited to, the treatment of corns, calluses, plantar keratosis and nail trimming;

14. **Blood pressure** cuffs and monitors;

15. **Marriage counseling**;

16. Services or supplies provided **in connection with or as a result of any service or supply that is not a Covered Expense**, except as specifically stated under the Other Covered Expenses section of the Plan (e.g. the Qualifying Clinical Trial benefit).

17. **Wrong surgeries.** Charges 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 and objects left in patients after surgery;

18. **Aquatic therapy;** or

19. **Biofeedback.**

PRESCRIPTION DRUG BENEFITS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and home delivery service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Benefits.

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

You must either show Your ID card at the time You obtain Your Prescription Drug at a Network Pharmacy or provide the Network Pharmacy with identifying information that can be verified by OptumRx during regular business hours.

If You do not show Your ID card or provide verifiable information at a Network Pharmacy, You will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for Outpatient Prescription Drugs that are considered a Covered Expense.

The Plan pays benefits at different levels for tier 1, tier 2, and, if applicable, tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug may change periodically, as frequently as monthly, based on the Formulary Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, for the most current information, You can visit www.UMR.com, and navigate to the Pharmacy section, or call OptumRx at 877-559-2955.

Each tier is assigned a Co-pay or Participation, which is the amount You pay when You visit the pharmacy or order Your medications through home delivery. Your Co-pay or Participation will also depend on whether or not You visit the pharmacy or use the home delivery service; see the Prescription Schedule of Benefits for further details. Here is how the tier system works:

Tier 1 is Your lowest Co-pay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

Tier 2 is Your middle Co-pay or Participation option. Consider a tier 2 drug if no tier 1 drug is available to treat Your condition.

Tier 3, if applicable, is Your highest Co-pay or Participation option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

For Prescription Drugs at a retail Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Charge that OptumRx agreed to pay the Network Pharmacy.

For Prescription Drugs from a home delivery Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount; or
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by visiting www.UMR.com, and navigating to the Pharmacy section, or call OptumRx at 877-559-2955.

To obtain Your Prescription from a retail pharmacy, simply present Your ID card and pay the Co-pay, Participation, or Deductible amount. The Plan pays benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

Note: Pharmacy Benefits apply only if Your Prescription is for a Covered Expense, and not for Experimental, Investigational, or Unproven Services. Otherwise, You are responsible for paying 100% of the cost.

Home Delivery

The home delivery service may allow You to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic Illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the home delivery service, all You need to do is complete a patient profile and enclose Your Prescription order. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after Your order is received. If You need a patient profile form, or if You have any questions, You can reach OptumRx at 877-559-2955.

The Plan pays home delivery benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

You may be required to fill an initial Prescription Drug order and obtain one or more refills through a retail pharmacy prior to using a home delivery Network Pharmacy.

Note: To maximize Your benefit, ask Your Physician to write Your Prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Co-pay, Participation, or Deductible amount for any Prescription order or refill if You use the home delivery service, regardless of the number of days' supply that is written on the order. Be sure Your Physician writes Your home delivery or refill for a 90-day supply, not a 30-day supply with three refills.

Designated Pharmacy

If You require certain Prescription Drugs, OptumRx may direct You to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see the Definitions in this section for the definition of Designated Pharmacy.

Want to lower Your out-of-pocket Prescription Drug costs?

Consider tier 1 Prescription Drugs, if You and Your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

OptumRx Pharmacy and Therapeutics (P&T) Committee and Formulary Management Committee make the final approval of Prescription Drug placement in tiers. In their evaluation of each Prescription Drug, the Committees takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or prior authorization requirements should apply.

Economic factors may include:

- The acquisition cost of the Prescription Drug;
- The net cost of the Prescription Drug; and
- Available rebates and assessments on the cost effectiveness of the Prescription Drug.

When considering a Prescription Drug for tier placement, the Committees review clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The Formulary Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes may occur as frequently as monthly and may occur without prior notice to You.

Prescription Drug, Prescription Drug List (PDL), and Formulary Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide You and Your Physician in choosing the medications that allow the most effective and affordable use of Your Prescription Drug benefit.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist, or You to obtain prior authorization. OptumRx will determine if the Prescription Drug, in accordance with Your plan's approved guidelines, is both:

- A Covered Expense as defined by the Plan; and
- Not Experimental, Investigational, or Unproven.

The Plan may also require You to obtain a prior authorization so OptumRx can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Physician.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or You are responsible for obtaining prior authorization from OptumRx.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a non-Network Pharmacy, You or Your Physician is responsible for obtaining prior authorization from OptumRx as required.

To determine if a Prescription Drug requires prior authorization, You can visit www.UMR.com, and navigate to the Pharmacy section, or call OptumRx at 877-559-2955. The Prescription Drugs requiring prior authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after OptumRx reviews the documentation provided and determines that the Prescription Drug is not a covered health service or it is an Experimental, Investigational, or Unproven service.

We may also require prior authorization for certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation, or activation requirements associated with such programs through the Internet at www.UMR.com, and navigating to the Pharmacy section, or call OptumRx at 877-559-2955.

Limitation on Selection of Pharmacies

If OptumRx determines that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, You may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the designated single Network Pharmacy.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per Prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.UMR.com, and navigate to the Pharmacy section, or call OptumRx at 877-559-2955. Whether or not a Prescription Drug has a supply limit is subject to OptumRx's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan and OptumRx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name drug may change. As a result, Your Co-pay, Participation, or Deductible amount may change. You will pay the amount applicable for the tier to which the Prescription Drug is assigned.

Special Programs

The *employer* and OptumRx may have certain programs in which You may receive an enhanced or reduced benefit based on Your actions such as adherence to or compliance with medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.UMR.com, and navigating to the Pharmacy section, or call OptumRx at 877-559-2955.

Rebates and Other Discounts

OptumRx and the *employer* may, at times, receive rebates for certain drugs on the PDL. OptumRx does not pass these rebates and other discounts on to You, nor does OptumRx take them into account when determining Your Co-pays.

OptumRx and a number of its affiliated entities conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants, and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. OptumRx is not required to pass on to You, and does not pass on to You, such amounts.

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

- **Prescription products that:**
  - Are necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed medical professional; and
  - Can be obtained only by Prescription and are dispensed in a container labeled "Rx only"; and
  - Are the following non-prescription products prescribed by a duly licensed medical professional:
    - Compounded medications of which at least one ingredient is an FDA Prescription Drug;
    - Any other medications that, due to state law, may be dispensed only when prescribed by a duly licensed medical professional; and
    - In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits.

- **Prescription Drugs lost as a direct result of a natural disaster.** Covered Persons will be given the opportunity to prove that Prescription Drugs otherwise considered Covered Expenses under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

- **Home Delivery Prescriptions.** The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the home delivery pharmacy identified by OptumRx. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Schedule of Benefits. By law, Prescription products may not be mailed to a Covered Person outside the United States.

- **Diabetic Supplies.** Some diabetic supplies may be covered.

- **Tobacco and Nicotine Cessation.** Some tobacco cessation products may be covered, and may be subject to quantity and age restrictions and prior therapy review.

- **Vaccines.** Some vaccines may be covered, and may have limitations depending on whether the vaccine is administered in a pharmacy or a clinic.

Covered Expenses apply only to certain Prescription Drugs and supplies, You can visit www.UMR.com, and navigate to the Pharmacy section, or call OptumRx at 877-559-2955, for information on which specific Prescription Drugs and supplies are covered.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover
In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.UMR.com, and navigate to the Pharmacy section, or call OptumRx at 877-559-2955, for information on which Prescription Drugs are excluded.

Excluded medications are:

- For any condition, Injury, sickness or Mental Health Disorder arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which benefits are provided in the medical (not in the Prescription Drug Benefits) portion of the Plan;
- Available over-the-counter that do not require a Prescription order or refill by federal or state law before being dispensed, unless the Plan has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision;
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription order or refill. Compounded drugs that are available as a similar, commercially available Prescription Drug;
- Compound drugs that contain non-FDA approved bulk ingredients, available as similar commercial Prescription Drugs, and contain non-covered over-the-counter products;
- Dispensed outside of the United States, except in an Emergency;
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- The amount dispensed (days' supply or quantity limit) that exceeds the supply limit;
- The amount dispensed (days' supply or quantity limit) that is less than the minimum supply limit;
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committees;
- Prescribed, dispensed, or intended for use during an Inpatient stay;
- Prescription Drugs, including new Prescription Drug products or new dosage forms, that OptumRx and the *employer* determines do not meet the definition of a Covered Expense;
- Used for conditions and/or at dosages determined to be Experimental, Investigational, or Unproven, unless OptumRx and the *employer* have agreed to cover an Experimental, Investigational, or Unproven treatment, as defined in the Glossary of Terms;
- Tobacco cessation products (unless the Plan covers);
- Vaccines (unless the Plan covers);
- Vitamins, except for the following, which require a Prescription:
  - Prenatal vitamins;
  - Vitamins with fluoride; Single-entity vitamins.
- Certain Prescription products excluded by formulary design, utilization management programs, or benefit design;

- Certain new Prescription Drugs to market until the Committees have reviewed them for formulary placement;
- Certain Prescription products with over-the-counter products in the same therapeutic class.

DEFINITIONS

Brand-name means a Prescription Drug that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- Identified by OptumRx as a Brand-name drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Brand-name" by the manufacturer, the pharmacy, or Your Physician may not be classified as Brand-name by OptumRx.

Co-payment (or Co-pay) means the amount You are required to pay for certain Prescription Drugs.

Committees means OptumRx Pharmacy and therapeutics Committee and Formulary Management Committee.

Designated Pharmacy means a pharmacy that has entered into an agreement with OptumRx, or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Expanded Preventive List means a list of certain preventive medications that waive any applicable Deductibles. This list is subject to periodic review and modification. You can visit www.umr.com, and navigate to the Pharmacy section, or call OptumRx at 877-559-2955, for information on which specific Prescription Drugs and supplies are included on this list.

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by OptumRx as a Generic drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Generic" by the manufacturer, the pharmacy, or Your Physician may not be classified as Generic by OptumRx.

Network Pharmacy means a retail or home delivery pharmacy that has:

- Entered into an agreement with OptumRx to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by OptumRx as a Network Pharmacy.

Participation means the percentage of the cost You are required to pay for certain Prescription Drugs.

PDL: see Prescription Drug List (PDL).

Pharmacy and Therapeutics (P&T) Committee means the Committee at OptumRx that is responsible for the reviews of Prescription Drugs for inclusion on the Formulary and creates criteria, policies, and procedures for such inclusion including, but not limited to, clinically appropriate quantity restrictions, step therapies, and prior authorizations.

Prescription Drug means a medication, product, or device that has been approved by the Food and Drug Administration and that may, under federal or state law, be dispensed only using a Prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs also include:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices; and
  - Glucose monitors.

Prescription Drug Charge means the rate OptumRx has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.UMR.com, and navigating to the Pharmacy section, or calling OptumRx at 877-559-2955.

Specialty Drug List means the list(s) of Specialty Drugs. The Specialty Drug List is maintained and updated by OptumRx from time to time. The Specialty Drug List(s) applicable to the Plan will be provided to the client upon request.

Specialty Drugs means the Prescription Drugs that include at least one or more of the following:
- Biotechnology drugs;
- Orphan drugs used to treat rare diseases;
- Typically high-cost drugs;
- Drugs administered by oral or injectable routes, including infusions in any Outpatient setting;
- Drugs requiring ongoing frequent patient management or monitoring or focused, in-depth member education;
- Drugs that require specialized coordination, handling, and distribution services for appropriate medication administration;
- Infusion or injectable drugs professionally administered by a health care professional or in a health care setting (but excluding supplies or the cost of administration); or
- Therapy requiring management and/or care coordination by a health care provider specializing in the member's condition. Specialty Drugs do not include any Prescription Drugs that:
  - Require nuclear pharmacy sourcing;
  - Are preventive immunizations; or
  - Are administered only in an Inpatient setting.

Specialty Pharmacy means a facility that is duly licensed to operate as a pharmacy and to dispense Specialty Drugs. Specialty Pharmacies include pharmacies that OptumRx or its affiliates own or operate.

Therapeutic Class means a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent means when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge, also known as the retail price, means the amount charged to customers who have no health coverage for Prescription Drugs.

SECTION 2 DEFINITIONS

DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the *plan*. Defined words appear in *italic* throughout the *plan*.

Accident
A happening by chance and without intention or design. A happening, which is unforeseen, unexpected and unusual at the time it occurs.

Actively at Work
Performing on a regular basis all normal employment duties for at least 30 hours per week. Duties may be at the *employer's* business or another location if *you* are required to travel on the job. *You* will be *actively at work* on each day of paid vacation if *you* were *actively at work* on *your* last regular working day. *You* will be *actively at work* on each non-working holiday if *you* were *actively at work* on *your* last regular working day. Status of employment on a regular basis is determined at the *employer* level.

Ambulatory Surgical Center
Any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing surgery and does not provide services or accommodations for patients to stay overnight.

Amendment
A written document that changes the provisions of the *plan*. It must be duly authorized and signed by the *plan administrator*.

Birthing Center
A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the *birthing center*; 2. Is directed by a *qualified practitioner* specializing in obstetrics and gynecology; 3. Has a *qualified practitioner* or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to *qualified practitioners* who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area *hospital* for *emergency* transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

Business Associate
A Business Associate is a person who provides, other than in the capacity of a *plan employee*, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for the Plan where the provision of the service involves the disclosure of individually identifiable health information from the Plan or from another Business Associate to the person.

Calendar Year
A 12 month period of time that starts on January 1 and ends on December 31.

Definitions - continued

Chronic Disability
A disability which meets all of the following requirements: 1) It is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) It is likely to continue indefinitely; 3) It results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living and economic self-sufficiency.

Claims Administrator
The person or firm employed by the *plan administrator* to provide clerical services to the *plan*. Clerical services include the processing of claims. If a *claims administrator* is not employed by the *plan administrator, claims administrator* will mean the *plan administrator*.

Complications of Pregnancy
A *sickness* or *injury* superimposed upon an otherwise normal pregnancy. The *sickness* or *injury* must have the potential to affect the course or outcome of the pregnancy, or the health of the mother or fetus. Examples of *Complications of Pregnancy* are preeclampsia, toxemia, gestational diabetes, hyperemesis, gravidarium, ectopic pregnancy, miscarriage and gynecological surgery performed in the six week postpartum period (other than elective sterilization) if the surgery is in connection with or results from the pregnancy.

Complications do not include false labor, occasional spotting, prescribed bed rest during pregnancy, morning sickness and similar conditions associated with a difficult pregnancy.

Confinement
Being a resident patient in a *hospital* for at least 15 consecutive hours per day. Being a resident bed patient in an *extended care facility* or other *qualified treatment facility* 24 hours a day. A *confinement* starts with *your* admission to a *hospital, extended care facility* or other *qualified treatment facility* and ends with discharge from the same facility. Successive *confinements* are considered one if:

1. Due to the same *injury* or *sickness*; and

2. Separated by fewer than 30 consecutive days when *you* are not confined.

If *you* experience an unexpected recurrence of *your* original *sickness* or *injury* after recovery or *you* have a new *sickness* or *injury*, the *Plan Administrator* may determine that *you* are entitled to a new period of *confinement*.

In all cases, the *Plan Administrator* determines whether a subsequent confinement is the same period of *confinement* or a new period of *confinement*.

Covered Dependent
An *employee's* eligible *dependent* who is properly enrolled in the *plan*.

Covered Employee
An *employee* who is eligible and properly enrolled in the *plan*.

Definitions – continued

Covered Expense
Expense not excluded by the *plan* that is incurred by *you* or *your* covered *dependents* due to an *injury* or *sickness*. Expenses must be incurred while *you* are covered for that benefit under this *plan*.

Covered Person
The *employee* or any *dependent*, when *you* are properly enrolled in the *plan*.

Custodial Care
Care to assist in the activities of daily living. Care that is not likely to improve *your sickness* or *injury*.

Dependent
1. A covered *employee's* legal spouse.

2. A covered *employee's* married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the *employee's* legal guardianship by court order; or a child placed with the *employee* for the purpose of adoption and for which the *employee* has a legal obligation to provide full or partial support; whose age is less than the limiting age.

   The limiting age for each *dependent* child is the last day of the month in which such child reaches age 26.

   Coverage may be extended (beyond age 26) for a *dependent* child if **all** of the following requirements are met:

   a. The *dependent* child is a full-time student, regardless of age, and
   b. The dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
   c. The dependent child was under age 27 when called to federal active duty.

   Dependent children who are eligible for this extension, covered under the *plan* and drop below full-time student status due to *injury* or *sickness* may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the *plan* by the child's attending *qualified practitioner*:

      1. the date the child's coverage would terminate for reasons other than not being a full-time student,
      2. 12 months from the date the child was no longer a full-time student.

   Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

3. A covered *employee's* grandchild. The parent of the child must be a covered *dependent* child who is not yet 18 years old for the grandchild to be covered.

If, from the date a covered *dependent* child reaches a limiting age, all of the following conditions exist at the same time:

1. The child is mentally or physically handicapped;

2. The child is incapable of self-sustaining employment;

Definition of Dependent – continued

3. The child is *dependent* on the covered *employee* for more than 50% support and maintenance. (This requirement does not apply to apply to children who are enrolled under a Qualified Medical Child Support Order because of the *employee's* divorce or separation decree.)

4. The child is unmarried;

5. The *employee* must still be covered under this *plan*.

that child will remain an eligible *dependent* of a covered *employee* or may be enrolled as the *dependent* of a new *employee*. If the child has not continuously satisfied all of the conditions above since reaching a limiting age, the child will not be eligible for coverage under the *plan*.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached. Such proof must be submitted within 30 calendar days after the date coverage for such *dependent* would normally end. The *plan* may, for three years, ask for additional proof at any time, after which such proof may not be requested more often than once a year. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

In any event, no person may be covered as both an *employee* and a *dependent* at the same time. If both parents are eligible for coverage under this *plan*, only one may enroll for *dependent* coverage.

Right To Check Dependent Eligibility
The *plan* reserves the right to check the eligibility status of a *dependent* at any time during the year. *You* and *your dependent* have an obligation to notify the *plan* when the *dependent's* eligibility status changes during the year. Please notify *your employer* of any status changes

Disability or Disabled
The inability of an *employee* to perform adequately the material and substantial duties of his or her regular occupation due to involuntary; medically proven and documented physical or mental impairment(s). The physical or mental impairment(s) causing the *disability* must be substantiated in objective, contemporaneous medical records and documentation. For purposes of this definition, the regular occupation is the position that the *covered employee* held on the date that the *plan administrator* determines to be the first day on which the *employee* was disabled.

Emergency
Any *injury* or *sickness* that would jeopardize or impair the health of the *covered person* if not treated immediately. An *emergency* may or may not be life threatening. A condition is considered to be an *emergency* care situation when a sudden and serious condition such that a *prudent layperson* could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an *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.

Employee
You when *you* are: regularly employed by the *employer* and paid a salary or earnings by the *employer*. This does not include part-time *employees*, limited part-time *employees*, seasonal *employees*, temporary *employees*, casual *employees*, leased *employees* or independent contractors.

Definitions - continued

Employer
Washington County, the sponsor of this group *plan*.

Enrollment Date
The first day of *your* eligibility period or if earlier, *your* effective date of coverage under this *plan*. If *you* are a *late applicant*, *your enrollment date* is the effective date of *your* coverage under this *plan*.

Essential Health Benefits
If the *plan* covers services that are included under the following categories, as defined under the Patient Protection and Affordable Care Act, the *plan* may not place annual or *lifetime* dollar limits on such services: 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, etc.

Expense Incurred
The amount charged for services and supplies needed to treat the *injury* or *sickness*. The *expense incurred* date is the date a supply or service is provided.

Extended Care Facility
A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:

1. Full-time bed care facilities for resident patients;

2. A *qualified practitioner's* services available at all times;

3. A registered nurse (R.N.) or *qualified practitioner* in charge and on full-time duty. With one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;

4. A daily record for each patient; and

5. Continuous skilled nursing care during convalescence from *sickness* or *injury*.

An *extended care facility* is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Family
A *covered employee* and the *covered employee's covered dependents*.

Family Member
Your lawful spouse. *Your* child, step-child or grandchild. *Your* parent, step-parent, grandparent, step-grandparent. *Your* brother or sister or step-brother or step-sister. Any person related in the same way to *your* covered *dependent*.

Definitions - continued

Health Savings Account
Health Savings Account (HSA) means a tax-exempt account administered by a qualified HSA trustee or custodian, established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a Qualified High Deductible Health Plan (QHDHP), has no other impermissible coverage under IRS rules, is not entitled to benefits under Medicare, and is not claimed as a *dependent* on another person's tax return. See Qualified High Deductible Health Plan (QHDHP).

Home Health Care
A formal program of care and intermittent treatment that is: Performed in the home; prescribed by a *qualified practitioner*; 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 *qualified practitioner*; 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 Agency
A public or private agency or organization which:

1. Specializes in providing medical care and treatment in the home;

2. Is primarily engaged in providing skilled nursing services and other therapeutic services;

3. Is duly licensed by all appropriate authorities;

4. Has a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) , and establishes policies to govern the services provided;

5. Has a *qualified practitioner* or registered nurse (R.N.) providing full-time supervision of the services provided;

6. Maintains a complete medical record on each patient;

7. Has a full-time administrator; and

8. Is certified by *Medicare.*

Home Health Care Plan
A formal, written plan made by the *covered person's qualified practitioner* 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*.

Definitions - continued

Hospice Care Agency
An agency which:
1. has the primary purpose of providing *hospice care* to hospice patients;

2. is licensed and operated according to the laws of the state in which it is located;

3. has obtained any required certificate of need;

4. provides 24-hour-a-day, seven-day-a-week service, supervised by a *qualified practitioner*;

5. has a full-time coordinator;

6. keeps written records of services provided to each patient;

7. has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients;

8. has a licensed social service coordinator;

9. establishes policies for the provision of *hospice care*; assesses the patient's medical and social needs and develops a program to meet those needs;

10. provides an ongoing quality assurance program;

11. permits area medical personnel to use its services for their patients; and

12. uses volunteers trained in care and services for non-medical needs.

Hospice Care
Palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients. It offers an assessment of the hospice patient's medical and social needs and a description of the care necessary to meet those needs. *Hospice care* must be provided under a written plan of *hospice care*. The plan must be established and reviewed by the *qualified practitioner* attending the person and the *hospice care agency*.

Hospice Care Program
A written plan of *hospice care* which is established and reviewed by a *qualified practitioner* and the *hospice care agency*, and describes palliative and supportive care to hospice patients and their *immediate families.*

Hospice Facility
A licensed facility or part of a facility which:
1. principally provides *hospice care*;

2. has 24 hour a day nursing services, provided under the direction of a registered nurse (R.N.);

3. has a full-time administrator;

4. keeps medical records of each patient;

Definition of Hospice Facility - continued

5. has an ongoing quality assurance program; and

6. has a *qualified practitioner* on call at all times.

Hospital
A facility that:

1. Maintains full-time facilities for bed care of resident patients;

2. Has a *qualified practitioner* and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing services;

4. Primarily provides diagnostic and treatment facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical services with a facility having a valid license to provide such surgical services.

Hospital does **not** include an institution, which is principally a rest home, nursing home, extended care facility or a home for the aged. *Hospital* does **not** include a place principally for alcoholics, drug addicts or persons with psychological disorders.

Immediate Family
Your spouse, children, parents, grandparents, brothers and sisters and their spouses. (For Hospice Care only, *your immediate family* is *your* parent, spouse and *dependent* children.)

Injury
Physical damage to *your* body caused by an external force. Damage must be due directly and independently of all other causes to an *accident*. Muscle tiredness or soreness is a *sickness* under the *plan*. Overexertion in an athletic or physical activity is a *sickness* under the *plan.*

Late Applicant
An *employee* who enrolls for coverage more than 31 days after they are eligible to be covered. A *dependent* who is enrolled for coverage more than 31 days (60 days for a newborn child or an adopted child) after they are eligible to be covered.

Lifetime
When used in reference to benefit maximums and limitations, the time *you* are covered under this *plan*. In no circumstances does *lifetime* mean *your* life span.

Medical Condition
A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

Definitions - continued

Medically Necessary
Medically Necessary means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the plan or our designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for *your sickness, injury*, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and

3. Not mainly for *your* convenience or that of *your qualified practitioner*; and

4. Is the most appropriate care, supply, or drug that can be safely provided to the member and that 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 Your Sickness, Injury or symptoms.

5. Clinical factors used when reviewing medical necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable *prior authorization* requirements.

The fact that a physician or *qualified practitioner* 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, shall be within our sole discretion.

UMR CARE (Care Management) 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 UM and revised from time to time), are available to *you* by calling UMR, Inc. at the telephone number shown on *your* ID card, and to *qualified practitioners*, physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare
Title XVIII, Parts A and B, of the Social Security Act as enacted and amended.

Negotiated Rate
The amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Definitions - continued

Named Fiduciary
Washington County, which has the authority to control and manage the operation of the *plan*.

Non-Essential Health Benefits
Any *covered expense* that is not an *essential health benefit*. Please refer to the *essential health benefits* definition.

Outpatient
A period of time during which *you* are not confined as a resident bed patient in a: *hospital*; *extended care facility*; or other *qualified treatment facility*.

Pediatric Services
Services provided to a *covered person* under 19 years of age.

PPO
Preferred Provider Organization. If a provider has contracted with the *PPO* Network, they are a *PPO* Provider. *PPO* providers furnish services at a discounted rate to the *plan*. If a provider has not contracted with the *PPO* Network, they are a Non-*PPO* provider.

Plan
This *plan* of benefits as established by the *employer*. The term *plan* includes any schedules, attachments and *amendments* to the *plan*. Prior, current and successive *plans* will be considered one *plan* and not separate and distinct *plans*. This Summary Plan Description provides a description of the *plan*.

Plan Administrator or Plan Sponsor
The *employer*, who is responsible for the day to day functions and engagement of the *plan*. The *plan administrator* may employ other persons or firms to process claims and perform other services.

Post-Service Claim
Any claim that is not a pre-service claim.

Pre-Service Claim
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the *plan* for the medical care.

Prior Authorization
The process of determining benefit coverage prior to service being rendered to a *covered person*. A determination is made based on medical necessity (*medically necessary*) criteria for services, tests or procedures that are appropriate and cost-effective for the *covered person*. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Definitions - continued

Protected Health Information
Protected Health Information means individually identifiable health information that is: transmitted or maintained in any form or medium; is created or received by a health care provider, the Plan an employee or health care clearinghouse; and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual.

Prudent Layperson
A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified High Deductible Health Plan
Qualified High Deductible Health Plan (QHDHP) means a health plan that meets the IRS requirements of a High Deductible Health Plan with respect to *deductibles* and out-of-pocket amounts for the purpose of being able to contribute to a *Health Savings Account* (HSA). See Health Savings Account (HSA).

Qualified Practitioner
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*. A *qualified practitioner's* services are not covered if the practitioner resides in *your* home or is a *family member*.

Qualified Treatment Facility
A facility that is duly licensed and operating within the scope of its license.

Reasonable Reimbursement
The amount the Plan determines to be the reasonable charge, allowing for variance of reimbursement among provider types and geographical adjustments where market conditions suggest it appropriate.

Sickness
1. A disease or disturbance in function or structure of *your* body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or systems of *your* body;

2. Muscle tiredness or soreness resulting from overexertion in a physical activity; or

3. Pregnancy.

Site of Care
Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Specialty Injectable
Specialty Injectable means a Prescription drug 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. Specialty injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Definitions - continued

Transitional Treatment
Treatment for nervous or mental disorders, alcoholism or other drug abuse that is provided in a less restrictive manner than Inpatient Treatment, but in a more intensive manner than Outpatient Treatment.

Urgent Care
Any care that in the opinion of *your qualified practitioner* is an urgent care situation. Any care that the use of non-urgent care time frames would put *your* life, health or ability to regain maximum function at risk.

Usual and Customary
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.

You and Your
You as the covered *employee* or covered retiree. Any of *your dependents*, unless otherwise indicated.

SECTION 3 ELIGIBILITY

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Employee Coverage section applies to *employees* hired on or after the effective date of this *plan*. The Dependent Coverage section applies to *dependents* that are added on or after the effective date of this *plan*.

Employees who were covered under any plan that this *plan* replaces will be covered on the effective date of this *plan*. Coverage will include *dependents* of such an *employee*. *You* must have met the eligibility requirements of the *plan*.

EMPLOYEE ELIGIBILITY

You are eligible for coverage under the *plan* if the following conditions are met:

1. *You* are an *employee* who meets the eligibility requirements of the *employer*. (Refer to the definition of "Actively at Work" in Section 2 (Definitions) of this *plan* for more information.) and

2. *You* satisfy an eligibility period of 30 consecutive days of regular employment with the *employer*

You are eligible to be covered on the first day of the month after the date *you* complete the eligibility period. This is *your* eligibility date.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms accepted by the *plan administrator*. Each *employee's* effective date is determined as follows:

1. *Your* completed forms are received by the *plan administrator* within 31 days of the date *you* are eligible. This is a timely enrollment. Y*our* coverage will be effective on *your* eligibility date.

2. *Your* completed forms are received by the *plan administrator* **more than** 31 days after the date *you* are eligible. This is **late enrollment**. *You* will not be eligible for coverage until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" and "Special Enrollment Rights" provisions of this *plan*.

Employee coverage will begin at 12:01 AM, Standard Time, on *your* effective date. *You* must actually begin performing work with the *employer* before coverage will be effective under the *plan*.

Please refer to the **Special Enrollment Rights** section of this *plan* for additional enrollment rights and events.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on the later of:

1. The date the *employee* is eligible for coverage, if the *employee* has *dependents* on that date;

2. The date of the *covered employee's* marriage for any *dependents* acquired on that date;

3. The date of birth of the *covered person's* natural born child;

4. The date a valid court order is issued which, by federal law or *plan* provision, requires the *plan* to provide coverage;

Dependent Eligibility – continued

5. For an adopted child: An adopted child is eligible for coverage on the date that a court makes a final order granting adoption or on the date that the child is legally placed with the *covered employee* for adoption, whichever is earlier. Coverage for the adopted child will begin on the date of eligibility if the required enrollment form for the adopted child is received by the *plan administrator* within 60 days of that date; or

6. For a legal ward: A legal ward is eligible for coverage on the date established by the court order as the date which *you* begin guardianship. Coverage for the legal ward will begin on the date he or she became eligible if:

   a. *You* have family coverage in effect; and

   b. The *Plan Administrator* receives the required enrollment form to add the legal ward within 30 days after he or she first became eligible.

   Note: Refer to the definition of "Dependent" in Section 2 of this Plan for information about eligible *dependents* under this *plan*.

Dependents may only be covered if the *employee* is covered. Check with *your employer* on how to enroll for *dependent* coverage.

When both parents are *employees* only one may enroll for *dependent* coverage. If both the *employee* and a *dependent* are eligible for *employee* coverage under this *plan*, each *covered expense* is payable only once and each *covered person* is covered only once.

DEPENDENT EFFECTIVE DATE OF COVERAGE

Each *dependent's* effective date of coverage is determined as follows:

1. If a *dependent's* completed enrollment forms are received by the *Plan Administrator* within 31 days of the *dependent's* eligibility date, that *dependent* is covered on his or her eligibility date.

2. An eligible newborn of a *covered person* is covered for 60 continuous days from the moment of birth. If the newborn's enrollment forms are received by the *Plan Administrator* within 60 days of the date of birth, then the newborn will be a *covered dependent* effective the moment of birth.

3. If the newborn's enrollment forms are received by the *Plan Administrator* more than 60 days and within one year after the date of birth and the Covered Employee makes all past due premium payments with interest at the rate of 5 ½% per year, than the newborn will be a *covered dependent* effective the moment of birth.

4. If *you* marry after *your* coverage is effective, *you* should apply for *family coverage* within 31 days of *your* marriage. If *you* do, *your family coverage* becomes effective on the date of the marriage.

5. If a *dependent's* completed enrollment forms are received by the *Plan Administrator* more than 31 days after the *dependent's* eligibility date, this is considered **late enrollment**. Such *dependent* will not be eligible to enroll for coverage until the next Annual Open Enrollment Period, except has shown under the "Changes in Status" and "Special Enrollment Rights" sections of this Plan.

Dependent coverage will begin at 12:01 AM, Standard Time, on the *dependent's* effective date of coverage under the *plan*.

Please refer to the **Special Enrollment Rights** section of this *plan* for additional enrollment rights and events.

RETIREE COVERAGE

If *you* were covered under this *plan* on the date of *your* retirement, *you* may be eligible for Retiree Coverage under this *plan* at the time of *your* retirement. Retiree Coverage will apply according to the terms defined by Your Employer or as defined in an applicable governing collective bargaining agreement.

If *you* elect Retiree Coverage, the Retiree Coverage will run concurrent with COBRA Continuation. If an alternate coverage (including retiree coverage) is offered, COBRA Continuation will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other *plan* provision (including retiree coverage) which runs concurrent with COBRA coverage.

NOTE: If *you* are *Medicare* eligible, claims must be submitted to *Medicare* first. After *Medicare* has processed *your* claim, the claim and the Medicare Explanation of Benefits (EOB) should be submitted to this *plan*.

ANNUAL OPEN ENROLLMENT PERIOD

Note: The Annual Open Enrollment Period also applies to retired *employees* and their *dependents*.

Each year, *your employer* will provide an Annual Open Enrollment Period. Once *you* have made *your* elections for the year, they cannot be changed until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" or "Special Enrollment Rights" provisions of this *plan*.

Your choices must be received by the *plan administrator* before the end of the Annual Open Enrollment Period. If *your plan* elections are not received by that time, *you* will not be able to enroll in the *plan* or change *plan* options until the next Annual Open Enrollment Period, except as shown under the "Changes in Status" or "Special Enrollment Rights" provisions of this *plan*.

Your employer will notify *you* when the Annual Open Enrollment Period is each year. Elections made during the Annual Open Enrollment Period will be effective January 1st.

Changes In Status

If *you* have a change in status, as defined by the IRS, *you* have 31 days from the date of that change to make new elections under this *plan*. Any changes in *your* elections must be consistent with *your* change in status or they will not be allowed. Change in status means only a change as stated below.

1. **Legal Marital Status**. *Your* marriage, divorce, legal separation, annulment or the death of *your* legal spouse;

2. **Number of Dependents**. An increase or decrease in the number of *dependents you* have due to birth, adoption, placement for adoption or the death of a dependent;

3. **Employment Status**. Any of the following events that change the employment status of *you* or *your* Dependent, including: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan;

4. **Dependent Status**. *Your dependent* satisfies or ceases to satisfy eligibility requirements for coverage;

5. **Residence**. Any change in residence for *you* or *your dependent*;

Annual Open Enrollment Period – continued

6. **FMLA Leave Status**. At the time a leave under the FMLA begins the Employee may change elections to the extent allowed under the federal Family and Medical Leave Act*;*

7. **COBRA Continuation**. *You* or *your dependent* become eligible for and elect continuation coverage under the Employer's group health plan as provided by COBRA or a similar State law;

8. **Judgment, Decree or Court Order**. An order resulting from a divorce, legal separation, annulment, change in legal custody or Qualified Medical Child Support Order as defined by ERISA which requires *you* or another individual to provide health coverage for *your dependent* child;

9. **Entitlement to Medicare or Medicaid**. A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for *you* or *your dependent*;

10. **HIPAA Special Enrollment Rights**. An event which qualifies as a special enrollment right under the Health Insurance Portability and Accountability Act;

11. **Significant Cost Increase**. Election changes are limited to increasing *your* election to cover the cost increase or changing the election to provide for a similar benefit offered by the employer;

12. **Significant Curtailment of Coverage**. An overall reduction in coverage provided to all participants that results in a general reduction in coverage under the plan;

13. **Addition or Elimination of a Benefit Option**. Election changes are limited to electing the new benefit option in the case of an added benefit option or electing a similar benefit in the case of the elimination of a benefit option;

14. **Changes in a Dependent's Coverage under Another Employer's Plan.** Election changes are limited to changes that result from a change under the plan of *your* spouse's, ex-spouse's or other *dependent's* employer. To qualify as a change in status under this *plan* the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

If *you* have questions regarding whether an event qualifies as a change in status, the *claims administrator* will answer them.

SPECIAL ENROLLMENT RIGHTS

If *you* have a special enrollment event, the *plan* will provide a new enrollment date for *you* to enter the *plan* as shown below. At that time, *you* will be able to enroll in the *plan* without being subject to the *late applicant* provisions of the *plan*. If the *plan* has more than one benefit option, *you* will be able to select from all options for which *you* are eligible.

Loss of Other Coverage

If *you* declined coverage under this *plan* in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other plan ends:

1. Due to *your* exhaustion of the maximum COBRA period;

2. Due to *your* involuntary loss of eligibility for any reason, or

3. *Employer* contributions towards the cost of the other coverage,

Special Enrollment Rights – continued

Then a special enrollment event has occurred. At that time, an *employee* or *dependent* may enroll in this *plan* as follows:

1. When the *employee* has a loss of coverage, the *employee* and any *dependent* may enroll. The *dependent* does not have to have had a loss of coverage at that time to be enrolled;

2. When a *dependent* has a loss of coverage, that *dependent* and the *employee* may enroll. The *employee* and the *dependent* are not required to have had a loss of coverage at that time to enroll.

You must enroll in this *plan* within 31 days of the date of a loss of other coverage to be a timely entrant to the *plan. You* **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this *plan* will not be effective until such proof is provided. Coverage under this *plan* will be effective on the day after coverage under the other group plan ends.

If *you* apply more than 31 days after the date the other coverage ends, *you* will be considered a *late applicant* and will be subject to the *late applicant* provisions of the *plan*.

Marriage

If *you*, as the *employee*, are now getting married, a special enrollment event will occur on the date of *your* marriage. At that time, *you* may enroll in this *plan*. Any *dependents* acquired on the date of *your* marriage may also be enrolled at this time.

You must enroll in this *plan* within 31 days of the date of *marriage* to be a timely entrant to the *plan*. Coverage under the *plan* will be effective on the date of *your* marriage.

If *you* apply more than 31 days after the date of *your* marriage, *you* will be considered a *late applicant* and will be subject to the *late applicant* provisions of the *plan*.

Birth, Adoption or Placement for Adoption

If *you* experience the birth of a *dependent* child, or the adoption or placement for adoption of a *dependent* child, a special enrollment event will occur on that date. At that time, *you* may enroll in this *plan*. Y*our dependent* spouse and the newborn child or adopted child may also be enrolled at this time.

You must enroll in this *plan* within 31 days (60 days for a newborn child or an adopted child) of the date of birth, adoption or placement to be a timely entrant to the *plan*. Coverage under the *plan* will be effective on the date of such an event.

If *you* apply more than 31 days (60 days for a newborn child or an adopted child) after the date of such an event, *you* will be considered a *late applicant* and will be subject to the *late applicant* provisions of the *plan*.

Limitations

This Special Enrollment Rights provision does not apply to *you* or *your dependents* if:

1. *You* are on an unpaid leave of absence (unless *you* have continued *your* coverage on this *plan* under *your* legal rights to coverage continuation (e.g. COBRA) or *you* are on leave under the Family and Medical Leave Act);

2. *You* are covered under the Retiree Coverage provision of this *plan*, if offered; or

3. *You* are covered under the Survivorship Continuation provision of this *plan*, if applicable.

MEDICAID/STATE CHILD HEALTH PLAN

If *you* and/or *your dependents* were covered under a Medicaid plan or State child health plan and *your* coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health plan coverage ends.

You must request coverage under this *plan* within 60 days after the date of termination of such coverage. Coverage under this *plan* will be effective on the date the other coverage ends.

If *you* apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, *you* will be considered a *late applicant* and will be subject to the *late applicant* provisions of the *plan*.

Premium Assistance

Current *employees* and their eligible *dependents* may be eligible for a special enrollment event 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*. *You* must request coverage under this *plan* within 60 days after the date the *employee* and/or *dependent* is determined to be eligible for such assistance. If *you* apply for coverage more than 60 days after this date *you* will be considered a *late applicant* and will be subject to the *late applicant* provisions of the *plan*.

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all *covered persons*. Any change in coverage will be effective on the date of change for all *covered persons*.

REHIRED EMPLOYEES AND REINSTATEMENT OF COVERAGE

If *your* coverage under this *plan* ends due to termination of employment, leave of absence, reduction of hours or layoff and *you* qualify for eligibility under this *plan* again (e.g. *you* are rehired or are considered to be rehired for purposes of the Affordable Care Act) within six months from the date *your* coverage ended, *your* coverage under this *plan* will be reinstated on the first day of the month after *you* are rehired or are considered to be rehired for purposes of the Affordable Care Act. If *your* coverage ends due to termination of employment, leave of absence or reduction of hours and *you* do not qualify for eligibility under this *plan* again (e.g. *you* are not rehired or considered to be rehired for purposes of the Affordable Care Act) within six months from the date *your* coverage under this *plan* ended, and *you* did not perform any hours of service that were credited within the six-month period, *you* will be treated as a new hire and will be required to meet all of the requirements of a new *employee*. Refer to the information about 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.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the *plan* terminates;

2. For any benefit, the date the benefit is removed from the *plan*;

3. The end of the period for which *your* last contribution is made, if *you* fail to make any required contribution towards the cost of coverage when due;

4. The date *you* enter the full-time military, naval or air service of any state or country. This includes being called to active duty as a member of a reserve unit of the armed forces;

5. The last day of the month in which *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;

6. For all *employees*, the last day of the month in which *your* termination of employment with the *employer* occurs or, if earlier, the last day of the month in which *you* are no longer *actively at work* as defined in this *plan*;

7. For all *employees*, the last day of the month in which *your* retirement occurs, unless *you* are eligible for, and elect, Retiree Coverage. (Eligible retirees may continue coverage under this *plan* until age 65. Coverage under this *plan* will terminate on the date such retiree turns age 65.)

8. For a *dependent*, the date the *employee's* coverage terminates;

9. For a *dependent*, the date *you* enter the military forces of any state or country. This includes being called to active duty as a member of a reserve unit of the armed forces;

10. For a *dependent* child, the last day of the month in which such *dependent* no longer meets this *plan's* definition of *dependent*. (Refer to the definition of Dependent in Section 2 of this *plan*.)

11. For an *employee's dependent* spouse, the date of entry of a judgement of divorce or annulment of the marriage;

12. For a *dependent* spouse or a *dependent* child, the date such *dependent* becomes covered as an *employee* under this *plan*;

13. For *employees* and *dependents*, the last day of the month if the *employee* requests voluntary termination of coverage while remaining eligible because of a change in status, Special Enrollment Right event or at the Annual Open Enrollment Period; or

14. The date the *employee* dies. (In the event an *employee* dies, coverage for the *employee's* covered *dependents* will end on the date the *employee* died.

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:

1. It has only a prospective effect;

2. It is attributable to non-payment of premiums or contributions; or

3. It is initiated by *you* or *your* personal representative.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

The *plan* cannot terminate *your* coverage due to age or *Medicare* status. An active *employee* that is eligible for *Medicare* due to age (age 65 or over) has the choice to:

1. Maintain coverage under this *plan*, in which case *Medicare* benefits would be secondary to this *plan*; or

2. End coverage under this *plan*, in which case *Medicare* would be the only coverage available to *you*.

An active *employee's* spouse who is eligible for *Medicare* due to age (age 65 or over) has the same choice.

Contact *your employer* for further information.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to Employers with 50 or more employees. It requires that coverage under this *plan* be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the *employee* as it would have been had FMLA leave not been taken.

If this *plan* is established while *you* are on FMLA, *your* coverage will be effective on the same date it would have been had *you* not taken leave. If the *plan* is amended while *you* are on FMLA leave, the changes will be effective for *you* on the same date as they would have been had *you* not taken leave.

EMPLOYEE ELIGIBILITY

An *employee* is eligible to take FMLA leave, if all of the following conditions are met:

1. The *employee* has been employed with the *employer* for a total of at least 12 months;

2. The *employee* has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and

3. The *employee* is employed at a worksite that employs at least 50 *employees*.

TYPES OF LEAVE

Coverage under this *plan* can be continued during a period of FMLA leave. The *employee* must continue to pay the *employee* portion of the *plan* contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the *employer*, for:

1. The birth of the *employee's* child;

2. The placement of a child with the *employee* for adoption. The placement of a child with the *employee* for foster care;

3. The *employee* taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;

4. The *employee* taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or

5. Any qualifying necessity that results from the *employee's* spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the *employer*, to care for a member of the armed forces that is the *employee's* spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.

FMLA - continued

Maximum Leave Period

The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the *employee* and the *employee's* spouse are both employed by the *employer*, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;

2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or

3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

Termination Before the Maximum Leave Period

If the *employee* decides not to return to work, coverage under the *plan* may end at that time.

If the *plan* contribution is not paid within 30 days of its due date, coverage under the *plan* may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an *employee* does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions

The *employer* has the right to recover the portion of *plan* contributions it paid to maintain coverage under the *plan* during an unpaid FMLA leave. If the *employee* does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the *employee's* control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the *employee's* return to work. Reinstatement will apply whether coverage under the *plan* was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the *plan* will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived.

DEFINITIONS

For this provision only, the following terms are defined as shown below:

Serious Health Condition is any *sickness*, *injury*, impairment or physical or mental condition that involves:

1. Inpatient care in a *hospital*, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;

FMLA - continued

2. Continuing treatment by a *qualified practitioner*, including any period of incapacity:

    a. for more than three consecutive calendar days, if a *qualified practitioner* is consulted two or more times during the period or a *qualified practitioner* is consulted at least once and a continuing treatment program is provided;
    b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
    c. due to a chronic condition (i.e. a condition which requires periodic treatments by a *qualified practitioner* and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
    d. which is permanent or long term due to a condition which requires the supervision of a *qualified practitioner*, but for which treatment is ineffective;
    e. to receive multiple treatments from a *qualified practitioner* for restorative surgery due to *accident* or *sickness* or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

    Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

Spouse is *your* lawful husband or wife.

Son or Daughter is *your* natural blood related child, adopted child, step-child, foster child, a child placed in *your* legal custody or a child for which *you* are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or

2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Parent is *your* natural blood related parent or someone who has acted as *your* parent in place of *your* natural blood related parent.

NOTE: To the extent that State or local law requires an *employer* to provide greater leave rights than those stated above, this *plan* will provide that greater right. For complete information regarding *your* rights under the FMLA, contact *your employer*.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that coverage under this *plan* be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the *plan* to similar active *employees*. This means that when coverage is changed for similar active *employees* it will also change for the person on leave. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the *employee* contribution required for active *employees*;

2. For leaves of 31 days or more, up to 102% of the full contribution.

This Act only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the Act.

Coverage provided due to this Act will reduce any coverage required by COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date *you* fail to return to employment with the *employer* after completion of *your* leave. *Employees* must return to employment within:

    a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
    b. 14 days of completing military service, for leaves of 31 to 180 days,
    c. 90 days of completing military service, for leaves of more than 180 days; or

2. 24 months from the date your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law requires that coverage be reinstated upon *your* return to work. Reinstatement will apply whether coverage under the *plan* was maintained during the leave or not. To be eligible for reinstatement *you* must be honorably discharged from the military service and return to work within:

1. The first, full business day after *your* military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

2. 14 days after *your* military service ends, for leaves of 31 to 180 days;

3. 90 days after *your* military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if *your* military service: causes a *sickness* or *injury*; or worsens a *sickness* or *injury*. *Your* failure to return within the times stated must be due to such a *sickness* or *injury*. In that case, *you* may take up to a period of two years to return to work. If for reasons beyond *your* control *you* cannot return to work within two years, *you* must return as soon as is reasonably possible.

USERRA - continued

On reinstatement, all provisions and limits of the *plan* will apply to the extent that they would have had *you* not taken leave. The eligibility period will be waived.

This does not waive the *plan's* limits on *sickness* or *injury*: caused by *your* military service; or worsened by *your* military service. The Secretary of Veterans Affairs will determine if *your* military service caused or worsened a *sickness* or *injury*.

NOTE: For complete information regarding *your* rights under the Uniformed Services Employment and Reemployment Rights Act, contact *your employer*.

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to employers that have 20 or more employees. The law requires these employers to offer covered individuals continuation coverage (COBRA) under the *plan* if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The *employer* cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active *employees* under the *plan.* This means that when coverage is changed for similar active *employees* it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Employee Rights to COBRA

An *employee* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *employee's* hours of work; or

2. The termination of the *employee's* employment. This will not apply if termination is due to gross misconduct on the *employee's* part.

Spouse Rights to COBRA

The spouse of an *employee* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *employee's* hours of work;

2. The termination of the *employee's* employment. This will not apply if termination is due to gross misconduct on the *employee's* part;

3. The death of the *employee*;

4. The end of the spouse's marriage to the *employee.* The marriage must end due to dissolution, annulment, divorce, or legal separation; or

5. The *employee* becoming entitled to *Medicare*.

Dependent Child Rights to COBRA

The *dependent* child of an *employee* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *employee's* hours of work;

2. The termination of the *employee's* employment. This will not apply if termination is due to gross misconduct on the *employee's* part;

3. The death of the *employee*;

COBRA – continued

4. The end of the *employee's* marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. The *employee* becoming entitled to *Medicare*; or

6. The child ceasing to be considered a *dependent* child as defined in this *plan.*

Electing COBRA

Each person covered by this *plan* has an independent right to elect COBRA for himself or herself. A *covered employee* or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the *employee's dependent* child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the *employee* during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, *you* have a right to elect COBRA. *You* also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the *employer* files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, *you* must inform the *Plan Administrator* within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. *You* must also inform the *Plan Administrator* within 60 days of a child no longer meeting the *plan's* definition of *dependent*. Notice must be provided within the 60-calendar day period that begins on the latest of:

1. The date of the qualifying event; or
2. The date on which there is a Loss of Coverage (or would be a loss of coverage) due to the original qualifying event; or
3. 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 *employer* must notify the *Plan Administrator* of: the *employee's* death; termination of employment; reduction in hours of work; or Medicare entitlement. The *employer* must also notify the *Plan Administrator* of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the *plan* for further information.

Within 14 days of receiving notice that one of the above events has happened, the *plan administrator* will notify *you* that *you* have the right to elect COBRA. If the *employer* and *plan administrator* are the same entity, notice of the right to elect will be provided within 44 days. Under the law *you* must elect COBRA within 60 days from the later of: the date *you* would lose coverage or cost would increase due to the qualifying event; or the date notice of *your* right to COBRA and the election form are sent.

COBRA – continued

The *plan administrator* must provide *you* with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If *you* elect COBRA within the 60 day period, COBRA will be effective on the date that *you* would lose coverage. If *you* do not elect COBRA within this 60 day period, COBRA will not be available. *Your* coverage under the *plan* will terminate.

If *you* elect COBRA, it is *your* duty to pay all of the monthly payments directly to the *plan administrator*. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The *plan* may add a 2% administration charge to that cost. The *plan* may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

The cost of continuation coverage is subject to change at least once per year. The timing of the one-year period is set by the *plan administrator*.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the *employer* maintain COBRA for up to:

1. 18 months, if due to the *employee's* termination of employment. Termination must be for reasons other than gross misconduct on the *employee's* part;

2. 18 months, if due to the *employee's* reduction in work hours;

3. 36 months, if due to the death of the *employee*;

4. 36 months, if due to the end of the *employee's* marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. 36 months, if due to the *employee* becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the *employee's* Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;

6. 36 months, if due to *your* ceasing to be a *dependent* child as defined in the *plan*; or

7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the *employer* files Chapter 11 bankruptcy. Upon the retiree's death, any covered *dependent* may elect COBRA for an additional 36 months from that date.

If *you* or a *dependent* are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if *you* or a *dependent* become disabled during the first 60 days of COBRA. *You* must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. *You* must provide notice to the *Plan Administrator* within 60 days of the later of:

1. The date of the Social Security Act disability determination;
2. The date that the qualifying event occurs;

COBRA – continued

3. The date the qualified beneficiary loses (or would lose) coverage due to the original qualifying event or the date that Plan coverage was lost due to the original qualifying event; or
4. 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.

This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, *you* will not be eligible for the extended period. If it is determined that *you* are no longer disabled, *you* must notify the *plan administrator* within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the *employee's* death; the *employee's* divorce; a child no longer meeting the definition of *dependent*. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active employee or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the last day of the month of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the *plan*, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other *plan* provision.

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The *employer* no longer provides a group benefit plan to any of its *employees;*

2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. *You* will have 30 days from the date of notice to make the additional payment;

3. *You* obtain another group plan after the date *you* elect COBRA;

4. *You* become entitled to *Medicare* after the date *you* elect COBRA;

5. There has been a final determination that *you* are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

COBRA – continued

Procedures for Providing Notice to the Plan

In order to maintain *your* rights under COBRA, *you* are required to provide the *plan* with notice of certain events, as described above. The *plan* will consider *your* obligation to provide notice satisfied if *you* provide written notice to the *plan administrator* that includes:

1. The *employee's* name and participant number;

2. The name of the individual(s) to whom the notice applies;

3. The reason for which notice is being provided; and

4. The address and phone number where *you* can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the *plan administrator's* address shown in this *plan*. *Your* notice will not satisfy *your* obligation if it is not provided within the time frame stated above for that notice.

Other Information

The *plan administrator* will answer any questions *you* may have on COBRA. *You* can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to *your* questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect *your* rights under COBRA, *you* should notify the *plan administrator* of any changes that affect *your* coverage. Such changes include a change for *you* or a family member in marital status; address; or other insurance coverage. When providing any notice to the *plan*, a copy should be maintained for *your* own records.

SPECIAL NOTICE

(Read This If Thinking Of Declining COBRA Continuation Coverage)

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

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 as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or 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.

SECTION 4 GENERAL PLAN INFORMATION

PLAN DESCRIPTION INFORMATION

The *employer* sets the benefits under the *plan*. The *employer* sets the rights and privileges of *plan* participants to those benefits. The *plan* pays benefits directly from the general assets of the *employer*, as needed.

This booklet is the Summary Plan Description (SPD) and Plan Document for the *plan*. It contains information on: eligibility; termination; benefits provided; and other general *plan* provisions. Copies of this SPD are posted on the County's website and intranet. Paper copies of the SPD are available upon request.

The purpose of this SPD is to set forth the provisions of this *plan*. The *plan* provides for the payment or reimbursement of eligible medical expenses.

PLAN NAME	Washington County Non-Grandfathered Employee Health Care Benefit Plan
TYPE OF PLAN	A self-funded welfare plan that provides medical benefits and prescription drug to covered *employees*, *dependents* and eligible retirees. This *plan* is not financed or administered by an insurance company. The *plan's* benefits are not guaranteed by a contract of insurance.
PLAN EFFECTIVE DATE	January 1, 2020 Revised January 1, 2011 Original
GROUP NUMBER	76-440225
PLAN YEAR FOR GOVERNMENT REPORTING	January 1 to December 31
PLAN ADMINISTRATOR/ PLAN SPONSOR	Washington County 432 East Washington Street West Bend, WI 53095-7986 (262) 335-4633
EMPLOYER IDENTIFICATION NUMBER	39-6005754
CLAIMS ADMINISTRATOR	UMR, Inc. 3100 AMS Boulevard P O Box 12003 Green Bay, WI 54307-2003 (800) 236-2515 (Toll-free)
AGENT FOR SERVICE OF LEGAL PROCESS	Washington County 432 East Washington Street West Bend, WI 53095-7986 (262) 335-4633
PHARMACY BENEFITS	OptumRx

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This *plan's* benefits are coordinated with benefits provided by other plans that cover *you*. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this *plan*. This provision will apply whether or not *you* file a claim under any other plan that covers *you*.

Effect on Benefits

Benefits will be reduced under certain circumstances when *you* are covered both under this *plan*, as described, and any other plan, as defined below, which provides similar benefits. Total reimbursement from all plans will not exceed 100% of the total *covered expenses* under this *plan.*

Definitions

A plan is any coverage that provides benefits for medical or dental expenses. Benefits may be provided by payment or service. Plan includes any of the following:

1. Group or franchise insurance coverage, whether insured or self-funded;
2. *Hospital* or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an *employer*, trustee, union, *employee* benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the *covered person's* membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total *covered expense*. These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the *reasonable reimbursement, the usual and customary charge, the negotiated rate,* or the fee schedule value of each service will be deemed to be the benefit paid for Non-*PPO* providers. In the case of a *PPO* provider, the negotiated *PPO* discount rate value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

Order of Benefit Determination

The Order of Benefit Determination rules determine which plan will pay first (which is the Primary Plan).

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.

Coordination of Benefits – continued

2. The plan that covers the person as an *employee* will be primary.

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:

   a. the plan of a parent who has primary physical placement will be primary,
   b. the plan of a step-parent that has primary physical placement will pay benefits next,
   c. the plan of a parent who does not have primary physical placement will pay benefits next, and
   d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

   Unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. In the case of a grandchild who is covered under the plans of both grandparents and/or parents:

   a. the plan of a parent who has primary physical placement will pay the benefits first,
   b. the plan of a parent who does not have primary physical placement will pay benefits next,
   c. the plan of a grandparent whose child has primary physical placement will pay benefits next,
   d. the plan of a grandparent whose child does not have primary physical placement will pay benefits next.

   Subject to the order of benefit determination stated above, if both grandparents in a household are providing coverage for a grandchild, the plan of the grandparent whose birthday (month and day) occurs first in the Calendar Year will pay before the plan of the other grandparent. If both grandparents in a household have the same birthday, the plan covering a grandparent for the longest period of time will pay benefits first.

   If the primary plan is not established by the above rules, the plan that has covered the grandparent or parent for the longest period will be primary.

7. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee. **There are two exceptions to this**: a) If a plan other than this *plan* does not include a provision similar to this one and, if as a result, the plans do not agree on the order of benefits, this rule will be ignored, and b) If a *dependent* is a Medicare beneficiary, any applicable federal Medicare regulations will supersede this rule.

8. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

When an individual is covered under a spouse's plan and also under his or her parent's plan, the primary plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the secondary plan.

Coordination of Benefits - continued

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this *plan* does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

In all cases, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare

In all cases, coordination with *Medicare* will conform to Federal Statutes and Regulations. Each person that is eligible for *Medicare* will be assumed to have full *Medicare* coverage. Full *Medicare* coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full *Medicare* coverage will be assumed whether or not it has been taken. *Your* benefits under this *plan* are subject to the allowable limiting charges set by *Medicare*. Benefits will be coordinated to the extent they would have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this *plan*, *you* agree to all of the following conditions. The payment of any claims by the *plan* is an advancement of *plan* assets. The *plan* has first priority to receive repayment of those *plan* assets out of any amount *you* recover. The *plan's* recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before *you* receive payment from that party. The *plan's* recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The *plan's* recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not you are made whole.

The *plan* will not pay attorney fees without the express written consent of the *plan administrator*. The *plan* will not pay any costs associated with any claim or lawsuit without the express written consent of the *plan administrator*.

If *you* are deceased, the rights and provisions of this section will apply equally to *your* estate. If *you* are legally incapacitated the rights and provisions of this section will apply equally to *your* legal guardian.

In consideration of the coverage provided by this *plan*, when *you* file a claim *you* agree to all of the following conditions. *You* will sign any documents that the *plan* considers necessary to enforce its recovery rights. *You* will do whatever is necessary to enable the *plan* to exercise its recovery rights. *You* will follow the provisions of this section and do nothing at any time to prejudice those rights. *You* will assign to the *plan* any rights *you* have for expenses the *plan* paid on *your* behalf. *You* will hold any settlement funds in trust, either in a separate bank account in *your* name or in *your* attorney's trust account, until all *plan* assets are fully repaid or the *plan* agrees to disbursement of the funds in writing, if *you* receive payment from any liable or responsible party and the *plan* alleges that some or all of those funds are due and owed to the *plan*. *You* will serve as a trustee over those funds to the extent of the benefits the *plan* has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the *plan*. It also includes any medical, dental or loss of time expense that may be payable by the *plan* in the future.

2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; *you* or *your* covered *dependent's* own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the *plan* in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of *your* benefits under this *plan*.

Right of Subrogation

If, after payments have been made under this *plan*, *you* have a right to recover damages from a responsible or liable party, the *plan* shall be subrogated to that right to recover. The *plan's* right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the *plan*.

Right of Reimbursement

If benefits are paid under this *plan* and *you* recover from a responsible or liable party by settlement, judgment or otherwise, the *plan* has a right to recover from *you*. Recovery will be in an amount equal to the amount of *plan* assets paid on *your* behalf. The *plan's* right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of *plan* assets that are paid or payable for any health care expenses under the *plan*.

Excess Coverage Provision

Benefits are not payable for an *injury* or *sickness* 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. In order to avoid delays in the paying of claims the *plan* may make payments on *your* behalf for *covered expenses* for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the *plan* and will be considered an advancement of *plan* assets to *you*.

This *plan* does not provide benefits or may reduce benefits for any present or future *covered expenses* that *you* have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the *plan*.

Workers' Compensation

This *plan* excludes coverage for any *injury or* sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the *plan* and *you* receive Workers' Compensation for the same incident, the *plan* has the right to recover. That right is described in this section. The *plan* reserves its right to exercise its recovery rights against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the *injury* or *sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by *you* or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.

You must notify the *plan administrator* of any Workers' Compensation claim *you* make. *You* agree to reimburse the *plan* as described above.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the *plan*.

ALTERNATE RECIPIENTS

If a court order requires a *covered person* to provide health care coverage for a *dependent* child, coverage must be provided to the child. Coverage may not be subject to *plan* requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of *dependents* are also waived for that child. If a *covered person* does not enroll the child in the *plan*, the *plan* must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an *employee* under the *plan* for the purpose of receiving *plan* information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the *plan*. They must be provided with a copy of the *plan's* Summary Plan Description (SPD). Any payments made by the *plan* must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services.

Such coverage will be effective on the date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSM) for a child, or a valid court order or administrative order for a spouse, which requires the employee to provide coverage for a child or spouse as specified in such orders.

A court order will not entitle the child to any benefits or coverage not already offered by the *plan*.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The *plan's* benefits may be amended by the *employer* at any time. The *plan* may be terminated by the *employer* at any time. Any changes to the *plan* will be communicated immediately by the *employer* to the persons covered under the *plan*.

If the *plan* is terminated, the rights of the *covered persons* to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. *Plan* assets will be allocated to the exclusive benefit of the *covered persons*. Any taxes and expenses of the *plan* may be paid from the *plan* assets.

ASSIGNMENT

Any assignment will only be applied if the provider will refund any payments made in error. The *plan* does not attest to the legal validity or effect of any assignment.

CLERICAL ERROR

A clerical error by the Employer, the *Plan Administrator* or the *Claims Administrator* will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

CONFORMITY WITH APPLICABLE LAWS

If any part of this *plan* conflicts with any law that applies to the *plan*, it is hereby amended to comply with that law.

CONTRIBUTIONS TO THE PLAN

The *plan* is funded by contributions from the *employer* and the *employees*, if required.

Any funds contributed by the *employees* are applied to the expenses of the *plan* as soon as is reasonably possible. Any excess funds are used to pay claims. The *employer* sets the amount of the *employee* contribution. The *employer* reserves the right to modify such contributions. All *employee* contributions are on a non-discriminatory basis.

DISCRETIONARY AUTHORITY

The *plan* has the sole right to interpret and prescribe the meaning, scope and application of each and all of the terms of the *plan,* including, without limitation, the benefits provided thereunder, the obligations of the *covered person* and the recovery rights of the *plan*. Such interpretation and prescription by the *plan* shall be final and uncontestable, unless it can be shown that the interpretation or determination was arbitrary or capricious.

FAILURE TO ENFORCE PLAN PROVISIONS

The *plan's* failure to enforce any part of the *plan* will not affect the right, thereafter, to enforce that provision. Such failure will not affect the right to enforce any other provision of the *plan*.

FRAUD

Fraud is a crime that can 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 Summary Plan Description and other *plan* materials. Please read them carefully and refer to all *plan* materials that *you* receive (i.e., COBRA notices). A few examples of events that require *plan* notification would be divorce, dependent child reaching the limiting age, 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 termination from the *plan,* and are subject to prosecution and punishment to the full extent under state and/or federal law. The *plan* will pursue all appropriate legal remedies in the event of fraud.

Covered persons must:

1. File accurate claims. If someone else, such as *your* spouse or another family member, files claims on the *covered person's* behalf, the *covered person* should review the form before signing it;

2. Review your Explanation of Benefits (EOB). Make certain that benefits have been paid correctly based on *your* knowledge of the *covered expense* and the services received;

3. Never allow another person to seek medical treatment under *your* identity. If *your plan* ID card is lost, report the loss to the *plan administrator* immediately;

4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of *your* knowledge; and

General Provision for Fraud – continued

5. Notify the *plan* when an event occurs that affects a *covered person's* eligibility.

To maintain the integrity of this *plan*, *covered persons* are encouraged to notify the *plan* whenever a provider:

1. Bills for services or treatment that have never been received; or

2. Asks a *covered person* to sign a blank claim form; or

3. 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 Explanation of Benefits (EOB), or who know of or suspect any illegal activity, should call the toll-free fraud hotline 1-800-356-5803. All calls are strictly confidential.

FREE CHOICE OF PROVIDER

The *covered person* has a free choice of any legally licensed provider. The *plan* will not interfere with the provider/patient relationship.

INTERPRETATION

This *plan* does not constitute a contract between the *employer* and any *covered person*. It will not be considered as an incentive or condition of employment.

LEGAL ACTIONS

You cannot bring an action to compel payment under the *plan* until at least 60 days after the date written proof of loss is submitted, proof of loss has been waived or the *plan* has denied full payment of *your* claim, whichever is earlier. *You* cannot bring action more than three years after proof of loss is required.

PAYMENT OF CLAIMS

All benefits (except for prescription drugs) will be paid directly to the provider of services, unless *you* direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of *you* or *your* covered *dependent*, upon death, will be paid at the *plan's* option to any one or more of the following: y*our* spouse; y*our dependent* children, including legally adopted children; y*our* parents; y*our* brothers and sisters; or y*our* estate.

Any payment made in good faith will fully discharge the *plan* of its obligations to the extent of such payment.

PHYSICAL EXAMINATION

The *plan* has the right to have *you* examined as often as reasonably necessary while a claim is pending. Such examination will be at the *plan's* expense.

PRIVACY

The *employer*, who is the sponsor of this *plan*, will receive protected health information. The information may be identified to the individual in some cases. The *employer* is limited in how it may use this information. Its uses and disclosures must be necessary to carry out *plan* functions. The *plan* functions must relate to payment or health care operations, as defined in 45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy. It may also use or disclose the information as required by law.

Prior to receiving any protected health information the *employer* must certify to the *plan* that it agrees to:

1. Not use or disclose the information, except as stated above;

2. Require that any agent or subcontractor of the *employer* agree to the same limits that apply to the *employer* prior to giving the information to them;

3. Not use or disclose the information for employment related decisions or actions;

4. Not use or disclose the information in connection with other benefit plans the *employer* may sponsor;

5. Report to the *plan* any use or disclosure that does not comply with this General Provision;

6. Make the information available for review by the person that it relates to;

7. Make the information available for amendment and include any amendments with it;

8. Provide the necessary information to give an accounting of disclosures;

9. Make its internal practices, books and records in relation to the information open for review by the Secretary of Health and Human Services;

10. Return or destroy all information when it is no longer needed. If that is not possible, limit any further use or disclosure to the reason it was not possible to return or destroy it;

11. Maintain adequate separation between the *plan* and itself. Access to the information will be limited to members of the *employer's* Human Resources and Finance Departments that work with the *plan*. These individuals will receive the minimum necessary information to carry out the *plan* functions they perform; and

12. Provide an effective process to address non-compliance by the *employer* or its agents or subcontractors.

PRONOUNS

All personal pronouns used in the *plan* include either gender. This will be true unless its use clearly indicates otherwise.

PROTECTION AGAINST CREDITORS

Benefit payments under the *plan* are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will be void. If the *plan* finds that such an attempt has been made, it, at its sole discretion, may terminate *your* interest in the payments. The *plan* will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the *covered person*. Such payment will fully discharge the *plan* to the extent of the payment.

REPRESENTATIONS

All representations by a *covered person* are material and relied upon in providing coverage under the *plan*.

RIGHT TO NECESSARY INFORMATION

The *plan* may require certain information in order to apply the provisions of this *plan*. To get this information the *plan* may release or obtain information from any party it needs to. The exchange of such information will not require *your* consent. Any party may include an insurance company, organization or person. Information will only be exchanged to the extent needed to implement the provisions of the *plan*. *You* agree to furnish any information needed to apply the *plan* provisions.

RIGHT TO RECOVER

The *plan* reserves the right to recover payments made under the *plan*. Recovery is limited to the amount that exceeds the amount the *plan* is obligated to pay. This right of recovery applies against:

1. Any person(s) to, for or with respect to whom such payments were made; and

2. Any insurance company or organization. If under the terms of this *plan*, it owes benefits for the same expense under any other plan.

The *plan* alone shall determine against whom this right of recovery will be exercised.

If benefits have been paid by any other plan that should have been paid by this *plan*, the *plan* reserves the right to directly reimburse such plan. Reimbursement will be to the extent needed to satisfy the obligations of this *plan*. Any such payment made in good faith will fully discharge the *plan* of its obligation to the extent of such payment.

SECURITY

The *employer*, who is the sponsor of this *plan*, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the *employer* certifies to the *plan* that it agrees to:

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

2. Require that any agent or subcontractor of the *employer* agrees to the same requirements that apply to the *employer* under this provision;

3. Report to the *plan* any security incident that the *employer* becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the *plan* and itself.

STATEMENTS

In the absence of fraud, all statements made by a *covered person* will be deemed representations and not warranties. A statement will not be used to contest coverage under the *plan* unless a signed copy of it has been provided to the *covered person*. If the *covered person* is deceased, the copy will be provided to their beneficiary.

TERMINATION OF THE PLAN

If the *plan* is terminated, the rights of the *covered persons* to benefits are limited to claims incurred and payable by the *plan* before the date of termination. *Plan* assets will be allocated and disposed of for the exclusive benefit of *covered persons*, except that any taxes and administration expenses may be paid from the *plan* assets.

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the Plan will notify You of its decision on Your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, *your* condition requires a shorter time frame. If more information is needed to make a decision on the claim, the *plan* will notify *you* of the specific information needed within 24 hours. *You* will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the *plan* will give its decision on the claim. If *you* fail to provide the information requested by the *plan*, the *plan* will provide *you* with its decision on the claim within 48 hours of the end of the period that *you* were given to provide the information.

If *you* fail to follow the *plan* procedure for a Pre-Service Claim, the *plan* will notify You within 24 hours of the *plan's* receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for *you* to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a *plan* amendment. This will not apply if the benefit is being stopped due to the termination of the Plan.

Requests to extend a pre-authorized treatment that involves Urgent Care must be responded to within 24 hours or as soon as possible if, *your* condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-Urgent Care claim. The *plan* may extend this period by 15 days if *you* are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the *plan's* control. If an extension is due to the need for additional information, the *plan* will notify *you* of the specific information needed. *You* will then have 45 days from the receipt of the notice to provide the requested information.

Time of Claim Determination - continued

If You fail to follow the *plan* procedure for a non-Urgent Care Pre-Service Claim, the *plan* will notify *you* within five days of the *plan's* receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims

Within 30 days of receipt of the claim. The *plan* may extend this period by 15 days if *you* are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the *plan's* control. If an extension is due to the need for additional information, the *plan* will notify *you* of the specific information needed. *You* will then have 45 days from the receipt of the notice to provide the requested information.

WORKERS' COMPENSATION NOT AFFECTED

This *plan* is not issued in lieu of Workers' Compensation coverage. It does not affect any requirement for coverage by any Workers' Compensation Law. It does not affect any requirement for coverage by any Occupational Disease Act.

CLAIM APPEAL PROCEDURE

A two-level appeal process is available under this *plan*, followed by the Federal External Review Program. The first and second levels of appeal are to the *Claims Administrator* (UMR, Inc.).

1. First Level of Appeal - Internal (mandatory appeal)
2. Second Level of Appeal - Internal (voluntary appeal)
3. Federal External Review Program

FIRST LEVEL OF APPEAL (MANDATORY)

You may appeal the denial of a claim, a utilization review decision or a rescission of coverage determination by following these procedures:

1. File a written request, with the *Claims Administrator*, for a full and fair review of the claim by the *plan*;
2. Request to review documents pertinent to the administration of the *plan*; and
3. Submit written comments and issues outlining the basis of *your* appeal.

A request for a review must be filed with the *Claims Administrator* within 180 days after receipt of the claim denial. If *your* request for review is not received within 180 days, *your* right to appeal the claim denial is forfeited.

If *your* request for review is received within 180 days, a full and fair review of the claim will be held by the *Claims Administrator*. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the *plan* will provide that information 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 the *Claims Administrator* is unable to provide *you* with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be tolled to allow *you* a reasonable opportunity to respond to the new or additional evidence.

Claim Appeal Procedure – continued

After the review, the *plan's* decision will be made to *you* in writing. It will include specific reasons for the decision as well as specific references to the *plan* provisions on which the decision is based. *You* will be notified of the *plan's* decision as follows. (**Note**: The timelines shown below will apply only to the mandatory appeal level. The Second Level of Appeal (voluntary appeal level) will not be subject to specific timelines.)

1. For Urgent Care claims, within 72 hours or as soon as possible if *your* condition requires a shorter timeframe;

2. For Pre-Service Claims, within 30 days or as soon as possible if *your* condition requires a shorter timeframe; or

3. For Post-Service Claims, within 60 days.

An expedited appeal process is available for Urgent Care cases.

SECOND LEVEL OF APPEAL (VOLUNTARY)

If *you* disagree with the *plan's* decision on the first level of appeal, *you* may appeal the denial to the *Claims Administrator* (UMR, Inc.) a second time by using the procedures outlined below:

This voluntary appeal process is available only after *you* have followed the mandatory (First Level of Appeal) process shown above. *You* are not required to following this internal level of appeal before taking outside legal action.

Request for Review

Upon completion of the first level of appeal, any participating *covered employee* or beneficiary who has been affected by a decision to deny a claim for benefits, a utilization review decision or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the *Claims Administrator* to review the claim again.

The written request must be submitted to the *Claims Administrator* within **sixty (60) days** after receipt of the *plan's* decision on the first level of appeal. A request shall be deemed submitted when actually received at the principal office of the Trust. The request shall be accompanied by any evidence and argument the participating *covered employee* or beneficiary wishes to present.

Review

You may submit written comments, documents, records, and other pertinent information to explain *you* believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted**.**

The second review will take into account all comments, documents, records, and other information submitted that relates to the claim 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 or the first appeal, and are not under the supervision of those individuals.

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 or first appeal, 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 *your* request, regardless of whether or not the *plan* relies on their advice in making any benefit determinations.

Claim Appeal Procedure – continued

After the claim has been reviewed, *you* will receive written notification letting *you* 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 *you.*

Regarding the above voluntary appeal level, the *plan* agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after *you* have followed the mandatory appeal level as required above. This *plan* also agrees that it will not charge *you* a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if *you* elect to pursue a claim in court before following this voluntary appeal process. *Your* decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on *your* rights to any other benefits under the *plan*. If *you* have any questions regarding the voluntary level of appeal including applicable rules, *your* right to representation (i.e., to appoint a personal representative), or other details, please contact the *plan*.

The written decision of the *Claims Administrator* shall be based on the record at the review and shall be final, except as otherwise required by law.

Appeals should be sent within the prescribed time period as stated above to the following addresses:

Send 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 COORDINATOR
OPTUMRX
PO BOX 25184
SANTA ANA CA 92799

FEDERAL EXTERNAL REVIEW PROGRAM

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 only applies if the adverse benefit determination is based on:

1. Clinical reasons;

2. The exclusion for experimental or investigational services or unproven services;

3. Determinations related to *your* entitlement to a reasonable alternative standard for a reward under a wellness program;

4. Determinations related 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); or

5. As otherwise required by applicable law.

Federal External Review Program - continued

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to *you* after exhausting the appeals process identified above and *you* receive a decision that is unfavorable, or if UMR, Inc. failed to respond to *your* appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither *you* nor UMR, Inc. nor *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 as indicated below.

Notice of the right to external review for *pre-service* appeals should be sent to:

UHC APPEALS – UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, *you* may fax *your* request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for *post-service* appeals should be sent to:

UMR, INC.
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 *covered person's* name, address, and member ID number;

3. *Your* designated representative's name and address, when applicable;

4. 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.

All requests for an independent review must be made within four (4) months of the date *you* receive the adverse benefit determination. *You*, *your* treating physician 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 *covered expense* by the *plan*. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or *your employer*. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

Federal External Review Program - continued

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:

1. All relevant medical records;

2. All other documents relied upon by UMR, Inc. in making a decision on the case; and

3. All other information or evidence that *you* or *your* physician has already submitted to UMR, Inc.

If there is any information or evidence *you* or *your* physician wish to submit in support of the request that was not previously provided, *you* may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information 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, Inc. with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as 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.