PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) DENVER CO

Health Benefit Summary Plan Description
7670-00-415014

Restated 01-01-2023

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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PLAN INFORMATION

Plan Name	PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) GROUP HEALTH BENEFIT PLAN
Name And Address Of Plan Administrator	PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) 1301 PENNSYLVANIA ST DENVER CO 80203
Name, Address, And Phone Number Of Plan Administrator	PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) 1301 PENNSYLVANIA ST DENVER CO 80203 800-759-7372
Named Fiduciary	PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA)
Claims Appeal Fiduciary For Medical Claims	UMR
Plan Administrator Identification Number Assigned By The IRS	84-6000472
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical and pharmacy claims.
Name And Address Of Agent For Service Of Legal Process	PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) 1301 PENNSYLVANIA ST DENVER CO 80203
Funding Of The Plan	Plan Administrator and Retiree Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your Plan Administrator.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Retirees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	January 1 through December 31

Compliance

It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

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

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001: PPO # 1

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

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

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

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

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

	TIER 1 Premium Designation Providers UHC Choice Plus	**TIER 2 NON-Premium Designation Providers UHC Choice Plus**	**TIER 3 OUT-OF-NETWORK**
Individual Lifetime Maximum		$5,000,000	
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible:			
• Per Person	$3,500	$3,500	$7,000
• Per Family	$7,000	$7,000	$14,000
– Individual Embedded Deductible	$3,500	$3,500	$7,000
Note: Embedded Deductible Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than Their Embedded Individual Deductible Amount.			
Plan Participation Rate, Unless Otherwise Stated Below:			
• Paid By Plan After Satisfaction Of Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum ***Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than Their Embedded Individual Out-Of-Pocket Maximum Amount.***	 $10,000 $20,000 $10,000	 $10,000 $20,000 $10,000	 $20,000 $40,000 $20,000
Ambulance Transportation: **Ground:** • Paid By Plan After In-Network Deductible **Air:** • Maximum Benefit Per Occurrence • Paid By Plan After In-Network Deductible	 80%	 $50,000 80%	 80%
Breast Pumps: • Maximum Benefit Per Pregnancy • Paid By Plan After Deductible	 100% (Deductible Waived)	1 Breast Pump 100% (Deductible Waived)	 60%
Cardiac Rehabilitation Phase 2: • Maximum Visits Per Cardiac Event • Paid By Plan After Deductible	 80%	36 Visits 80%	 60%
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: • Paid By Plan After Deductible	 100% (Deductible Waived)	 100% (Deductible Waived)	 60%
Durable Medical Equipment: • Paid By Plan After Deductible **Hearing Aid Batteries:** To Age 18 • Paid By Plan After Deductible	 80% 80%	 80% 80%	No Benefit

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Emergency Services / Treatment:			
Urgent Care:			
• Co-pay Per Visit	$75	$75	$75
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	100% (Deductible Waived)
Walk-In Retail Health Clinics:			No Benefit
• Co-pay Per Visit	$40	$40	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Emergency Room / Emergency Physicians:			
• Paid By Plan After In-Network Deductible	80%	80%	80%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			
• Maximum Days Per Calendar Year		100 Days	
• Paid By Plan After Deductible	80%	80%	60%
Hearing Services:			
Exams, Tests: To Age 18			
• Paid By Plan After Deductible	80%	80%	60%
Hearing Aids: To Age 18			
• Paid By Plan After Deductible	80%	80%	60%
Note: Initial And Replacement Hearing Aids Will Be Supplied Every Five Years.			
Implantable Hearing Devices:			
• Paid By Plan After Deductible	80%	80%	60%
Home Health Care Benefits:			
• Maximum Visits Per Calendar Year		100 Visits	
• Paid By Plan After Deductible	80%	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.			

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Hospice Care Benefits:			
Hospice Services:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Bereavement Counseling:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Respite Care:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Hospital Services:			
Pre-Admission Testing:			
• Paid By Plan After Deductible	80%	80%	60%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Advanced Imaging Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Advanced Imaging Charges In A Freestanding Radiology Center:			
• Co-pay Per Service	$500	$500	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Outpatient Lab And X-Ray Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Surgery / Surgeon Charges:			
• Paid By Plan After Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Outpatient Surgery In A Freestanding Surgical Center:			
• Co-pay Per Visit	$1,000	$1,000	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Outpatient Surgeon And Other Services In A Freestanding Surgical Center:			
• Paid By Plan After Deductible	100%	100%	60%
Physician Clinic Visits In An Outpatient Hospital Setting - Facility Claim:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim:			
• Co-pay Per Visit - Primary Care Physician	$0	$40	Not Applicable
• Co-pay Per Visit - Specialist	$40	$60	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Manipulations:			
• Paid By Plan After Deductible	80%	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits. Medical Necessity Review Is Based On Chiropractic Designation And Procedure Code.			
Maternity:			
Routine Prenatal Services:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:			
• Paid By Plan After Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:			
Inpatient Services / Physician Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Residential Treatment:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Office Visit:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Telehealth:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Nursery And Newborn Expenses:			
• Paid By Plan After Deductible	80%	80%	60%
Note: Deductible And / Or Co-pay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).			
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting:			
This Section Does Not Apply To: ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility**			
Primary Care Physician Visit:			
• Co-pay Per Visit	$0	$40	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Specialist Visit:			
• Co-pay Per Visit	$40	$60	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
The Co-pays Will Not Apply To: ➢ **Independent Lab** ➢ **Services Billed By Radiologist Or Pathologist Including Independent Radiology Facility (Freestanding Radiology Facility)**			
Physician Office Services:			
• Paid By Plan After Deductible	80%	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			
Preventive / Routine Physical Exams At Appropriate Ages:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Immunizations:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Note: Foreign Travel Immunizations Will Not Be Covered.			
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Mammograms And Breast Exams:			
• Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:			
• Paid By Plan After Deductible	80%	80%	60%
Note: First Mammogram Per Calendar Year Covered At Preventive / Routine Benefits Regardless Of Diagnosis.			
Preventive / Routine Pelvic Exams And Pap Tests:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine PSA Test And Prostate Exams:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Hearing Exams:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Tobacco Addiction: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Care Benefits For Children Include: **Preventive / Routine Physical Exams:** • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Immunizations: • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.***	100% (Deductible Waived)	100% (Deductible Waived)	

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Preventive / Routine Screenings At Appropriate Ages:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Autism Screening: From Age 0 To 21			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab, And X-Rays:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Hearing Exams:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Prosthetic Devices:			No Benefit
• Paid By Plan After Deductible	80%	80%	
Sterilizations:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Telehealth:			
Mental Health And Substance Use Disorders:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
All Other Services:			
• Co-pay Per Visit - Primary Care Physician	$0	$40	Not Applicable
• Co-pay Per Visit - Specialist	$40	$60	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Therapy Services: **Occupational / Physical / Speech Outpatient Hospital Therapy:** • Paid By Plan After Deductible	80%	80%	60%
Occupational / Physical / Speech Office Therapy: • Co-pay Per Visit - Specialist	$40	$60	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits.			
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:			
• Maximum Benefit Per Calendar Year		$500	
• Paid By Plan After In-Network Deductible	80%	80%	80%
All Other Covered Expenses: • Paid By Plan After Deductible	80%	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 002: PPO # 2

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

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

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

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

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

	TIER 1 Premium Designation Providers UHC Choice Plus	**TIER 2 NON-Premium Designation Providers UHC Choice Plus**	**TIER 3 OUT-OF-NETWORK**
Individual Lifetime Maximum		$5,000,000	
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible:			
• Per Person	$6,000	$6,000	$12,000
• Per Family	$12,000	$12,000	$24,000
– Individual Embedded Deductible	$6,000	$6,000	$12,000
Note: Embedded Deductible Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than Their Embedded Individual Deductible Amount.			
Plan Participation Rate, Unless Otherwise Stated Below:			
• Paid By Plan After Satisfaction Of Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum:			
• Per Person	$16,000	$16,000	$32,000
• Per Family	$32,000	$32,000	$64,000
– Individual Embedded Out-Of-Pocket Maximum	$16,000	$16,000	$32,000
Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than Their Embedded Individual Out-Of-Pocket Maximum Amount.			
Ambulance Transportation:			
Ground:			
• Paid By Plan After In-Network Deductible	80%	80%	80%
Air:			
• Maximum Benefit Per Occurrence		$50,000	
• Paid By Plan After In-Network Deductible	80%	80%	80%
Breast Pumps:			
• Maximum Benefit Per Pregnancy		1 Breast Pump	
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Cardiac Rehabilitation Phase 2:			
• Maximum Visits Per Cardiac Event		36 Visits	
• Paid By Plan After Deductible	80%	80%	60%
Contraceptive Methods And Contraceptive Counseling Approved By The FDA:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Durable Medical Equipment:			No Benefit
• Paid By Plan After Deductible	80%	80%	
Hearing Aid Batteries: To Age 18			
• Paid By Plan After Deductible	80%	80%	

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Emergency Services / Treatment:			
Urgent Care:			
• Co-pay Per Visit	$75	$75	$75
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	100% (Deductible Waived)
Walk-In Retail Health Clinics:			No Benefit
• Co-pay Per Visit	$40	$40	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Emergency Room / Emergency Physicians:			
• Paid By Plan After In-Network Deductible	80%	80%	80%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			
• Maximum Days Per Calendar Year		100 Days	
• Paid By Plan After Deductible	80%	80%	60%
Hearing Services:			
Exams, Tests: To Age 18			
• Paid By Plan After Deductible	80%	80%	60%
Hearing Aids: To Age 18			
• Paid By Plan After Deductible	80%	80%	60%
Note: Initial And Replacement Hearing Aids Will Be Supplied Every Five Years.			
Implantable Hearing Devices:			
• Paid By Plan After Deductible	80%	80%	60%
Home Health Care Benefits:			
• Maximum Visits Per Calendar Year		100 Visits	
• Paid By Plan After Deductible	80%	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.			

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Hospice Care Benefits:			
Hospice Services:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Bereavement Counseling:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Respite Care:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Hospital Services:			
Pre-Admission Testing:			
• Paid By Plan After Deductible	80%	80%	60%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Advanced Imaging Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Advanced Imaging Charges In A Freestanding Radiology Center:			
• Co-pay Per Service	$500	$500	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Outpatient Lab And X-Ray Charges:			
• Paid By Plan After Deductible	80%	80%	60%
Outpatient Surgery / Surgeon Charges:			
• Paid By Plan After Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Outpatient Surgery In A Freestanding Surgical Center:			
• Co-pay Per Visit	$1,000	$1,000	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Outpatient Surgeon And Other Services In A Freestanding Surgical Center:			
• Paid By Plan After Deductible	100%	100%	60%
Physician Clinic Visits In An Outpatient Hospital Setting - Facility Claim:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim:			
• Co-pay Per Visit - Primary Care Physician	$0	$40	Not Applicable
• Co-pay Per Visit - Specialist	$60	$80	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Manipulations:			
• Paid By Plan After Deductible	80%	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits. Medical Necessity Review Is Based On Chiropractic Designation And Procedure Code.			
Maternity:			
Routine Prenatal Services:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:			
• Paid By Plan After Deductible	80%	80%	60%
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:			
Inpatient Services / Physician Charges:			
• Paid By Plan After Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Residential Treatment: • Paid By Plan After Deductible	80%	80%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges: • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Office Visit: • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Telehealth: • Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible And / Or Co-pay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).***	80%	80%	60%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility** **Primary Care Physician Visit:** • Co-pay Per Visit • Paid By Plan After Deductible	 $0 100% (Deductible Waived)	 $40 100% (Deductible Waived)	 Not Applicable 60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Specialist Visit:			
• Co-pay Per Visit	$60	$80	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
The Co-pays Will Not Apply To: ➢ **Independent Lab** ➢ **Services Billed By Radiologist Or Pathologist Including Independent Radiology Facility (Freestanding Radiology Facility)**			
Physician Office Services:			
• Paid By Plan After Deductible	80%	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			
Preventive / Routine Physical Exams At Appropriate Ages:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Immunizations:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Note: Foreign Travel Immunizations Will Not Be Covered.			
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Mammograms And Breast Exams:			
• Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:			
• Paid By Plan After Deductible	80%	80%	60%
Note: First Mammogram Per Calendar Year Covered At Preventive / Routine Benefits Regardless Of Diagnosis.			
Preventive / Routine Pelvic Exams And Pap Tests:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine PSA Test And Prostate Exams:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Hearing Exams:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Tobacco Addiction: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Care Benefits For Children Include: **Preventive / Routine Physical Exams:** • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Immunizations: • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.***	100% (Deductible Waived)	100% (Deductible Waived)	

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Preventive / Routine Screenings At Appropriate Ages:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Autism Screening: From Age 0 To 21			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab, And X-Rays:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Hearing Exams:			
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
Prosthetic Devices:			No Benefit
• Paid By Plan After Deductible	80%	80%	
Sterilizations:			
• Paid By Plan After Deductible	100%	100%	60%
Telehealth:			
Mental Health And Substance Use Disorders:			
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
All Other Services:			
• Co-pay Per Visit - Primary Care Physician	$0	$40	Not Applicable
• Co-pay Per Visit - Specialist	$60	$80	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Therapy Services:			
Occupational / Physical / Speech Outpatient Hospital Therapy:			
• Paid By Plan After Deductible	80%	80%	60%

	TIER 1 Premium Designation Providers UHC Choice Plus	TIER 2 NON-Premium Designation Providers UHC Choice Plus	TIER 3 OUT-OF-NETWORK
Occupational / Physical / Speech Office Therapy:			
• Co-pay Per Visit - Specialist	$60	$80	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits.			
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:			
• Maximum Benefit Per Calendar Year		$500	
• Paid By Plan After In-Network Deductible	80%	80%	80%
All Other Covered Expenses:			
• Paid By Plan After Deductible	80%	80%	60%

TRANSPLANT SCHEDULE OF BENEFITS The program for Transplant Services at Designated Transplant Facilities is: Optum Benefit Plan(s) ALL	
Transplant Services: Designated Transplant Facility	
Transplant Services: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 $1,000,000 Per Covered Transplant 80%
Travel And Housing: • Maximum Benefit Per Transplant • Paid By Plan	 $10,000 100% (Deductible Waived)
Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

PRESCRIPTION SCHEDULE OF BENEFITS OPTUM RX Benefit Plan(s) 001: PPO # 1	
Individual Lifetime Maximum	$5,000,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name and Nonpreferred Generic) **Co-pay For Each Supply By** Participating Pharmacy For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction-Treating Tablets.	For Up To A 31-Day Supply: $10 $75 $100 $0
By Optum Rx Home Delivery • Covered Person's Co-pay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name and Nonpreferred Generic) **Co-pay For Up To A 90-Day Supply By** Optum Rx Home Delivery For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction-Treating Tablets.	For Up To A 90-Day Supply: $20 $150 $200 $0
Specialty Drugs • Covered Person's Co-pay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Brand-Name And Some Generic) ***Note: Certain Specialty Prescription Drugs May Be Subject To A Separate Cost Share. For Further Information, Call 877-559-2955.*** ***Note: Optum Specialty Pharmacy Must Be Used To Fill Specialty Medication.***	For Up To A 31-Day Supply: $125 $125
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Up Front. The Covered Person May Then Submit A Claim Reimbursement Form With A Receipt To Optum Rx For Reimbursement. Reimbursement For Covered Prescription Drugs Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.

Note: When the Covered Person purchases a brand-name product that has a generic equivalent, they must pay the applicable brand Co-pay (or Deductible, if applicable) plus the difference in cost between the generic drug and the brand-name drug when the medical professional has not specified a brand-name drug or has not indicated that the brand-name drug is Medically Necessary. This difference is not applied to preferred brand-name products in the High Priced Generic strategy.

PRESCRIPTION SCHEDULE OF BENEFITS OPTUM RX Benefit Plan(s) 002: PPO # 2	
Individual Lifetime Maximum	$5,000,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name and Nonpreferred Generic) **Co-pay For Up To A 90-Day Supply By** Optum Rx Home Delivery For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction-Treating Tablets.	For Up To A 31-Day Supply: $20 $100 $125 $0
By Optum Rx Home Delivery • Covered Person's Co-pay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name and Nonpreferred Generic) **Co-pay For Up To A 90-Day Supply By** Optum Rx Home Delivery For The Following Diabetes Supplies: Non-meter Blood Test Strips, Urine Test Strips, Lancets, Alcohol Swabs, And Reaction-Treating Tablets.	For Up To A 90-Day Supply: $40 $200 $250 $0
Specialty Drugs • Covered Person's Co-pay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Brand-Name And Some Generic) ***Note: Certain Specialty Prescription Drugs May Be Subject To A Separate Cost Share. For Further Information, Call 877-559-2955.*** ***Note: Optum Specialty Pharmacy Must Be Used To Fill Specialty Medication.***	For Up To A 31-Day Supply: $150 $150
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Up Front. The Covered Person May Then Submit A Claim Reimbursement Form With A Receipt To Optum Rx For Reimbursement. Reimbursement For Covered Prescription Drugs Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.

Note: When the Covered Person purchases a brand-name product that has a generic equivalent, he or she must pay the applicable brand Co-pay (or Deductible, if applicable) plus the difference in cost between the generic drug and the brand-name drug when the medical professional has not specified a brand-name drug or has not indicated that the brand-name drug is Medically Necessary. This difference is not applied to preferred brand-name products in the High Priced Generic strategy.

OPTUM ORTHOPEDIC HEALTH SUPPORT SCHEDULE OF BENEFITS Benefit Plan(s) ALL	
Orthopedic Health Support (OHS) Designated Centers Of Excellence (COE) Facility:	
Outpatient Hip, Knee, Spine Surgery:	
• Co-pay (Applies To Out-Of-Pocket Maximum)	$1,000
• Paid By Plan	100% (Deductible Waived)
Inpatient Hip, Knee, Spine Surgery:	
• Co-pay (Applies To Out-Of-Pocket Maximum)	$2,000
• Paid By Plan	100% (Deductible Waived)

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person pays each time certain services are received. The Co-pay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits.

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

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

PLAN PARTICIPATION

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

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

ANNUAL OUT-OF-POCKET MAXIMUMS

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

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

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy Co-pays and Plan Participation amounts for Prescription benefits.
- Any amounts over the Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays..

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

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

PROVIDER NETWORK

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

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

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

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

  UnitedHealthcare Choice Plus

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits.

UnitedHealth Premium® Program

To help people make informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program, including how to locate a UnitedHealth Premium® Physician, log onto www.umr.com or call the number on Your ID card.

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

Some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at a Network facility even if the provider is an Out-of-Network provider.
- Covered services provided by a Physician during an Inpatient stay (including surgeons and assistant surgeons during Emergency situations only) will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Covered services provided by an Emergency room Physician will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Wigs, toupees, and hairpieces will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.

Provider Directory Information

When requested, a Retiree will be given an electronic separate document, at no cost, that lists the participating Network providers for this Plan. The Retiree should share this document with other covered individuals in his or her household.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator, but that are not considered at the In-Network benefit level by the current claims administrator, may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Retiree's or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplants for patients under active treatment (e.g., seeing a Physician on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant).
- Being an Inpatient in a Hospital on the Covered Person's Effective Date.
- Post-acute Injury or surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral health (any previous treatment).

You or Your Dependent must call UMR within 30 prior to Your Effective Date or within 30 after Your Effective Date to see if You or Your Dependent is 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.

COVERED MEDICAL BENEFITS

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

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

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

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions (Elective).**

3. **Allergy Treatment,** including injections and sublingual drops, testing and serum.

4. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

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

7. **Augmentation Communication Devices** and related instruction or therapy.

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

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

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

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

9. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.

10. **Breast Reductions** if Medically Necessary.

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

12. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

13. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

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

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

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

16. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

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

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

    The following contraceptives will be processed under the Prescription Drug Benefits section of this SPD:

    - Contraceptive patches, oral tablets, or self-insertable vaginal devices containing contraceptive hormones (e.g., Nuva ring).

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

19. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), or for treatment of cleft palate, including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
- Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if necessary due to the patient's age of 5 years or under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
- Cleft palate and cleft lip conditions: Benefits are given for Inpatient care and Outpatient care, including:
  - Orofacial Surgery.
  - Surgical care and follow-up care by plastic surgeons and oral surgeons.
  - Orthodontics and prosthodontic treatment.
  - Prosthetic treatment such as obturators, speech appliances and prosthodontic.
  - Prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip.

  If You have a dental policy, the dental policy would be the main policy and must fully cover orthodontics and dental care for cleft palate and/or cleft lip conditions.

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

21. **Diabetic Supplies.**

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

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

- The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs including hearing aid batteries for Covered Persons under the age of 18 (ending on the 18th birthday), or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

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

- This Plan covers taxes and shipping and handling charges for Durable Medical Equipment.

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

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

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

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

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

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

28. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to and including, gender transition surgery.

29. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medical Necessity.

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

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

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

30. **Hearing Services** include:

- Exams, tests, services, and supplies to diagnose and treat a medical condition.
- Purchase or fitting of hearing aids for Children under the age of 18.
  - Audiological testing to measure the level of hearing loss and to choose the proper make and model of a hearing aid.
  - Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
  - Auditory training when it is offered using approved professional standards.
  - A new hearing aid may be a covered service when alterations to Your existing hearing aid cannot adequately meet Your needs or be repaired.
  - Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.
- Implantable hearing devices, including semi-implantable hearing devices.

31. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this SPD.)

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

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

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

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

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

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

34. **Hospital Services (Outpatient).**

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

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

36. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person. Once the patient is receiving fertility treatment to achieve pregnancy, diagnostic tests and treatments are then considered part of the infertility benefit.

Infertility Treatment does not include genetic testing. (See General Exclusions for details.)

37. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

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

39. **Maternity Benefits** for Covered Persons include:

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

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

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

42. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

    - Bariatric surgery, including, but not limited to:
      - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
      - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
      - Lap band (laparoscopic adjustable gastric banding).
      - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
    - Charges for diagnostic services.
    - Nutritional counseling by registered dieticians or other Qualified Providers.

    Bariatric surgery and complications from bariatric surgery are covered only when provided by a "Center of Excellence" provider.

    This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.

43. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of all Covered Persons: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth. Covered for the first 31 days if the mother is a covered enrollee.

44. **Nutritional Counseling.**

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

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

47. **One Pass Tool.**

48. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands, or ducts.
    - Excision of exostosis of jaws and hard palate.

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

50. **Oxygen and Its Administration.**

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

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

53. **Physician Services** for covered benefits.

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

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

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

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

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

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

    Please visit the following links for additional information:

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

57. **Private Duty Nursing Services** when Outpatient care is required and Medically Necessary (only covered under Home Health Care or Hospice Care). Coverage does not include Inpatient private duty nursing services.

58. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

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

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

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

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

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

Routine patient care costs for Qualifying Clinical Trials may include:

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

Routine costs for clinical trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
  - The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the NIH; and
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

60. **Radiation Therapy and Chemotherapy** when Medically Necessary.

61. **Radiology and Interpretation Charges.**

62. **Reconstructive Surgery** includes:

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

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

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

65. **Sexual Function:** Diagnostic services in connection with treatment for male or female impotence.

66. **Sleep Disorders** if Medically Necessary.

67. **Sleep Studies.**

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

69. **Sterilizations.**

70. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

71. **Surgery and Assistant Surgeon Services.**

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

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

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

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

74. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law and diagnoses, services, treatment, and supplies related to addiction to or dependency on nicotine.

75. **Transplant Services.** (Refer to the Transplant Benefits section of this SPD.)

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

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

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

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HOME HEALTH CARE BENEFITS

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

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

Information regarding Private Duty Nursing can be found elsewhere in this SPD.

Prior authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services may include:

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

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

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

The program for Transplant Services at Designated Transplant Facilities is:

Optum

DEFINITIONS

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

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

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

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

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

BENEFITS

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

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

COVERED EXPENSES

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

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

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

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) for certain conditions.
- Small bowel.

SECOND OPINION

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

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to Covered Person who is a recipient)

If the Covered Person lives more than 75 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.
- Lodging at or near the transplant facility, including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

TRANSPLANT EXCLUSIONS

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

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

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

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

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

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

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

PRESCRIPTION DRUG BENEFITS

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 Optum Rx 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 UMR at 866-683-6435.

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, Is a higher 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.

Tier 4 - Is Your highest Co-pay or Participation option, Specialty medications are defined as an injected, infused, oral or inhaled medications that may need ongoing clinical oversight and extra education. Specialty medications have unique storage and / or shipping methods and typically, may not be available at retail pharmacies. They may need infusion or home nursing.

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

- The applicable Co-pay;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Charge that Optum Rx 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 UMR at 866-683-6435.

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 UMR at 866-683-6435.

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, Optum Rx 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

Optum Rx 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 take 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. Optum Rx 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.

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 Optum Rx.

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 UMR at 866-683-6435. The Prescription Drugs requiring prior authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after Optum Rx 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 UMR at 866-683-6435.

Limitation on Selection of Pharmacies

If Optum Rx 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 UMR at 866-683-6435. Whether or not a Prescription Drug has a supply limit is subject to Optum Rx's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan and Optum Rx 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

PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) and Optum Rx 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 PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) at 866-683-6435.

Rebates and Other Discounts

Optum Rx and PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) may, at times, receive rebates for certain drugs on the PDL. Optum Rx does not pass these rebates and other discounts on to You, nor does Optum Rx take them into account when determining Your Co-pays.

Optum Rx 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. Optum Rx 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” or with similar language; 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 Optum Rx. 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.

- **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 UMR at 866-683-6435, 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 UMR at 866-683-6435 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. 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 may be available as a similar, commercially available Prescription Drug;
- Compound drugs that contain non-FDA approved bulk ingredients, available as a 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 Optum Rx and PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) 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 Optum Rx and PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) have agreed to cover an Experimental, Investigational, or Unproven treatment, as defined in the Glossary of Terms;
- Tobacco cessation products;
- Vitamins, except for the following, which require a Prescription:
  - Prenatal vitamins;
  - Vitamins with fluoride; and
  - 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 Optum Rx 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 Optum Rx.

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

Committees means Optum Rx 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.

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by Optum Rx 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 Optum Rx.

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

- Entered into an agreement with Optum Rx to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by Optum Rx 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 Optum Rx 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 Optum Rx 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 UMR at 866-683-6435.

Specialty Drug List means the list(s) of Specialty Drugs. The Specialty Drug List is maintained and updated by Optum Rx 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;
- 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 Medical Specialty Medications / Injectables 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.; or
- Drugs as determined by Optum Rx to be indicated for a specialty condition in which other specialty drugs are categorized.

Specialty Pharmacy means a facility that is duly licensed to operate as a pharmacy and to dispense Specialty Drugs. Specialty Pharmacies include pharmacies that Optum Rx 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.

HEARING AID BENEFITS

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.

MENTAL HEALTH BENEFITS

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

COVERED BENEFITS

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

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

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

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

ADDITIONAL PROVISIONS AND BENEFITS

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

MENTAL HEALTH EXCLUSIONS

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

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:

  - Personality disorders; or
  - Behavior and impulse control disorders; or
  - "Z" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

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

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

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

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

ADDITIONAL PROVISIONS AND BENEFITS

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

SUBSTANCE USE DISORDER EXCLUSIONS

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

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

Utilization Management

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

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts the Utilization Review Organization (see below) as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

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

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

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

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.
- Prosthetics over $1,000.
- Qualifying Clinical Trials.
- Chemotherapy (cancer diagnosis).
- Dialysis.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit https://fhs.umr.com/print/UM1428.pdf for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- Non-emergent air and ground ambulance.
- Hip, knee and spine surgery.

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

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

Medical Director Oversight. A UMR CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Complex Condition CARE, Complex Condition CARE +, or GenerationYou CARE Support Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Complex Condition CARE, Complex Condition CARE +, or GenerationYou CARE Support opportunities are identified by using a system-integrated, automated and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as Plan Administrator referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

Digital Capabilities

Covered Persons in UMR CARE programs will have access to CARE, powered by Vivify. This app provides additional support to You when working with a CARE nurse. The nurse assigns a CAREpath related to Your condition that You work through together. In addition, this app provides health and wellness tips and insight into Your health conditions.

Complex Condition CARE

Complex Condition CARE is available to Retirees and their spouses enrolled in the Plan. CARE nurse managers evaluate and coordinate post-hospitalization needs for members who have a high probability of subsequent readmission within 30 days. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to cardiovascular conditions, kidney failure, pulmonary conditions or infections, or liver/pancreas/gastrointestinal surgery.
- management of catastrophic and complex behavioral health and substance use disorders and support for identified members utilizing Inpatient/rehabilitation/residential facilities.

Additional CARE Provisions

Real Appeal Program: This Plan provides the Real Appeal Program, which represents a practical solution for weight-related conditions, with the goal of helping individuals at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support Covered Persons over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live, virtual coach. The experience will be personalized for each participant though an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Co-pays, Plan Participation, or Deductibles that need to be met when services are received as part of the Real Appeal Program. If Covered Persons would like to participate, or would like any additional information regarding the program, they can visit the Real Appeal website at Coach.WeRally.com.

CENTERS OF EXCELLENCE

Kidney Resource Services (KRS)

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

UMR CARE 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 CARE at 866-494-4502.

Optum Orthopedic Health Support (OHS)

Orthopedic Health Support (OHS) is a surgical program for Covered Persons 18 and older providing support before, during, and after surgery. Nurses help direct participants to quality Optum Centers of Excellence (COE) facilities and provide them with case management. A Covered Person seeking coverage for surgery should enroll in the OHS program as soon as the possibility of a surgical procedure arises, as enrollment is required prior to any prior authorization of surgical procedures. Call Optum at 1-888-936-7246 to enroll in the program.

Benefits of this program may include:

- Spine fusion surgery
- Disc surgery
- Total hip replacement surgery
- Total knee replacement surgery

All Covered Persons age 18 and older are eligible.

Enhanced benefits are offered to Covered Persons who utilize the program and/or Optum COE facility. (Refer to the Orthopedic Health Support Schedule of Benefits.)

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from his or her Plan Administrator's benefit plan.

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

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

- If one or more plans cover the same person as a dependent child:

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

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

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

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

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

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

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

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

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

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

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

MEDICARE

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

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

- This Plan generally pays first under the following circumstances:
  - You continue to be actively employed by the Plan Administrator and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the Plan Administrator, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former Plan Administrator. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by a Plan Administrator; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse has retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

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

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

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

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

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

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

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

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

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

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, Personal Injury Protection benefits, and/or medical payment benefits), under other coverage, or against any third party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

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

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

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

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

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

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

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

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

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

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

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

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GENERAL EXCLUSIONS

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

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Abdominoplasty.**

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

4. **Acupuncture Treatment.**

5. **Alternative / Complementary Treatment** including treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

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

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

8. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services,** unless determined to be Medically Necessary by the Plan.

9. **Auto Excess:** Illness or bodily Injury from a Motor Vehicle Collision for which there is a medical payment or expense provided or that is payable under any automobile coverage.

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

11. **Biofeedback Services**.

12. **Blood:** Blood donor expenses.

13. **Blood Pressure Cuffs / Monitors,** unless covered elsewhere in this SPD.

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

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

16. **Claims** received later than 12 months from the date of service.

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

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

19. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.

20. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) for which the individual is charged or a felony for which the individual is charged.

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

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

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

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

25. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

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

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

28. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

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

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

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

32. **Financial Counseling.**

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

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

35. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

36. **Growth Hormones.**

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

38. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

39. **Infertility Treatment:**

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

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

40. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

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

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

43. **Liposuction,** unless covered elsewhere in this SPD.

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

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

46. **Marriage Counseling.**

47. **Massage Therapy.**

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

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

50. **Nocturnal Enuresis Alarm** (Bed wetting).

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

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

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

54. **Nutrition Counseling,** unless covered elsewhere in this SPD.

55. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

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

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

58. **Palliative Foot Care.**

59. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

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

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

62. **Prescription Medication Written by a Physician:** A Covered Person with a written Physician's Prescription who obtains medication from a pharmacy should refer to the Prescription Drug Benefits section of this SPD for coverage.

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

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

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

66. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

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

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

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

70. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

71. **Services Provided By a School.**

72. **Sex Therapy.**

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

74. **Standby Surgeon Charges.**

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

76. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, not including pregnancy and maternity charges Incurred by a covered Retiree or covered spouse acting as a surrogate parent.

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

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

79. **Telemedicine.**

80. **Temporomandibular Joint Disorder (TMJ) Services:**

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

    This Plan does not cover orthodontic services.

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

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

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

84. **Vision Care,** unless covered elsewhere in this SPD.

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

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

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

88. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

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

90. **Workers' Compensation:** An Illness or Injury arising out of, or in the course of, any employment for wage or profit including self-employment, for which the Covered Person was entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force. If You are a Retiree with a second job or if You are covered as a Dependent under this Plan and You are self-employed or employed by a Plan Administrator that does not provide health benefits, Your claims may not be covered by the health plan. You will need to have other medical benefits to provide for Your medical care in the event that You are hurt on the job. In most cases, Workers' Compensation insurance will cover Your costs, but if You do not have such coverage You may end up with no coverage at all.

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

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

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

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

Pre-Determination

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

TYPE OF CLAIMS AND DEFINITIONS

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

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

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

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

PERSONAL REPRESENTATIVE

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

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

PROCEDURES FOR SUBMITTING CLAIMS

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

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should call the number on the back of the Pharmacy drug benefit identification card for further instructions on how to proceed.

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

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

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

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A Covered Person may request a Prescription claim form by writing to Optum Rx at PO Box 8082, Wausau WI 54402-8082, or by calling the number on the back of the Prescription drug card. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

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

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

HOW HEALTH BENEFITS ARE CALCULATED

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

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying.

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

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

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

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

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

- 110 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
  - A gap methodology may be utilized when CMS does not have rates published for certain procedural codes; or
  - 50 percent of the provider's billed charges when unable to obtain a rate published by CMS and/or gap methodology does not apply.

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

See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

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

NOTIFICATION OF BENEFIT DETERMINATION

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

Note: For Prescription benefits, a Covered Person will receive an EOB when he or she files a claim directly with Optum Rx. See "Procedures for Submitting Claims" for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment ending or being reduced.

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person’s loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.

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

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

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

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

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

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

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days or 180 calendar days for Prescription benefits following the date they received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why they 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 Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- 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 the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

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 the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

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

Note: Post-Service Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send 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
OPTUM RX
PO BOX 25184
SANTA ANA CA 92799

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

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

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or their authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

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

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

FRAUD

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

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

Each Covered Person must:

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

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

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

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

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PERA is required to provide this notice to you periodically. Please review it carefully and retain it. You are not required to take any action.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting: Colorado PERA, HIPAA Privacy Officer 1301 Pennsylvania Street, Denver, CO 80203, 1-800-759-7372, ext. 6271, or hipaaprivacy@copera.org. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we never share your information unless you give us written permission	• Marketing purposes. • Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example*: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long-term care plans.	*Example*: We use health information about you to develop better services for you.

Pay for your health services	• We can use and disclose your health information as we pay for your health services.	*Example*: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	*Example*: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: ➢ Preventing disease. ➢ Helping with product recalls. ➢ Reporting adverse reactions to medications. ➢ Reporting suspected abuse, neglect, or domestic violence. ➢ Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ➢ For workers' compensation claims. ➢ For law enforcement purposes or with a law enforcement official. ➢ With health oversight agencies for activities authorized by law. ➢ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

In addition to federal law, which permits the disclosure listed above, PERA is required to follow privacy rules set forth in Colorado statute, C.R.S. § 24-51-213. To the extent required by the Colorado statute, PERA and the Plan will obtain your (or your personal representative's) authorization before making such disclosures.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you. This notice is effective December 1, 2014.

THIS NOTICE OF PRIVACY PRACTICES APPLIES TO THE FOLLOWING ORGANIZATIONS

Colorado PERA's self-insured health, dental, and vision plans**.**

Colorado PERA, 1301 Pennsylvania Street, Denver, Colorado 80203, 1-800-759-7372, hipaaprivacy@copera.org.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the Plan Administrator reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder Therapy means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

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

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Retiree: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Retiree's or spouse's Legal Guardianship; a grandchild, as long as the Retiree's covered Dependent is the parent of the grandchild or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Retiree, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means a Retiree or Dependent who is enrolled under this Plan.
Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delay may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;

- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a

terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the Plan Administrator as an Independent Contractor, or an entity or individual who performs services to or on behalf of the Plan Administrator who is not an Employee or an officer of the Plan Administrator, and who retains control over how work is completed. The Plan Administrator who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not Inpatient on any day on which they are on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) 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.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and
- 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 has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body mass Index of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Motor Vehicle Collision means an Accident that occurs when a motor vehicle strikes or collides with another vehicle, a stationary object, a pedestrian, or an animal with no implied determination of fault.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

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

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Participating Pharmacy means a licensed entity, acting within the scope of its license in the state in which it dispenses, that has entered into a written agreement with Optum Rx and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who performs services payable under this Plan: a doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which they practice, the services being provided are within their scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION OF COLORADO (PERA) Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means a Plan Administrator who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders, or a Physician assistant / nurse practitioner regardless of specialty or practice type. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

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

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Retired Employee / Retiree means a person who was employed full-time by the Plan Administrator who is no longer regularly at work and who is now retired under the Plan Administrator's formal retirement program.

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

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, those specified in the definition of Primary Care Physician above.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That a Retiree is prevented from engaging in any job or occupation for wage or profit for which the Retiree is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Diagnosis of one or more of the following conditions is not considered proof of total disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Diseases - Clinical Modification manual (ICD-CM) in the following categories:

- Personality disorders; or
- Behavior and impulse control disorders; or
- "Z" codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for a Retiree or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Retiree.