SUMMARY PLAN DESCRIPTION

Westmoor Country Club

1427074

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Summary Plan Description

Westmoor Country Club Medical Plan

SECTION 1 - WELCOME

What this section includes:

- Can this Plan Change?
- How do you use this SPD?
- Your Responsibilities
- Claims Administrator and Plan Sponsor Responsibilities

Westmoor Country Club is pleased to provide you with this Summary Plan Description (SPD) which describes the health Benefits available to you and your covered family members under the Westmoor Country Club Welfare Benefit Plan. It includes summaries of:

- Who is eligible;
- Services that are covered, called Covered Health Care Services;
- Services that are not covered, called Exclusions;
- How Benefits are paid; and
- Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14: *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Can this Plan Change?

Westmoor Country Club intends to continue this Plan, but reserves the right, as they determine, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

United Healthcare Services, Inc. is a private healthcare claims administrator whose goal is to give you the tools you need to make wise healthcare decisions. United Healthcare Services, Inc. also helps your employer to administer claims. Although United Healthcare Services, Inc. will assist you in many ways, it does not guarantee any Benefits. Westmoor Country Club is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Westmoor Country Club Welfare Benefit Plan works. If you have questions, contact your Employer or call the number on the back of your ID card.

How Do You Use This SPD?

- Read the entire SPD, and share it with your family.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You may access the most current version of your SPD and any future amendments at www.myuhc.com.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14: *Glossary*.
- Westmoor Country Club is also referred to as Company.
- Capitalized words in the SPD have special meanings and are defined in Section 14: *Glossary*.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD controls.
- Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan. Your enrollment options, and the corresponding dates that coverage begins, are listed in Section 2: *When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as a Participant or a Dependent as those terms are defined in Section 14: *Glossary*.

Your Plan Sponsor may require you to make certain payments to them, in order for you to remain enrolled under the Plan. If you have questions about this, contact your Plan Sponsor.

Be Aware the Plan Does Not Pay for All Health Care Services

The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review Section 6: *Exclusions: What the Plan Will Not Cover* to become familiar with the Plan's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in Section 7: *How to File a Claim*.

Claims Administrator Responsibilities

Determine Benefits

The Claims Administrator makes administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. The Claims Administrator's decisions are for payment purposes only. The Claims Administrator does not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

The Claims Administrator had the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this SPD, the *Schedule of Benefits* and any Amendments.

- Make factual determinations relating to Benefits.

The Claims Administrator may assign this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time at the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in Section 5: *Additional Coverage Details* and in the *Schedule of Benefits*, unless the service is excluded in Section 6: *Exclusions: What the Plan Will Not Cover*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers

The Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See Section 7: *How to File a Claim*.

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings. The Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*.

Offer Health Education Services to You

The Claims Administrator may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but it is recommended that you discuss them with your Physician.

SECTION 2 - When Coverage Begins

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Who is Eligible for Coverage?

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For complete definition of Eligible Persons, Plan Sponsor and Participant, see Section 14: *Glossary*.

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week.

Dependent

Dependent generally refers to the Participant's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 14: *Glossary*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse, as defined in Section 14: *Glossary*.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you. A child is no longer eligible as a Dependent when the child reaches age 26 except as provided in Section 11: *Coverage for a Disabled Dependent Child*.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Westmoor Country Club Welfare Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Westmoor Country Club Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order (QMCSO)* or other court or administrative order, as described in Section 11: *Other Important Information*.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Claims Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Cost of Coverage

You and Westmoor Country Club share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Westmoor Country Club's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Westmoor Country Club reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting the Plan Sponsor.

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Plan Sponsor. The Plan Sponsor will submit the completed forms to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

To enroll, call the Plan Sponsor within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective as of the anniversary renewal date.

Important: If you wish to make allowed coverage changes due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

What If You Are Hospitalized When Your Coverage Begins?

The Plan will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Plan.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You must obtain prior authorization of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under Medicare

Your Benefits may also be reduced if you are enrolled in a Medicare plan but do not follow the rules of that plan. Please see How Are Benefits Paid When You Are Medicare Eligible? in Section 9: *Coordination of Benefits (COB)* for more information about how Medicare may affect your Benefits.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor and Claims Administrator must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

Thirty days prior to the renewal date of the Plan during which Eligible Persons can enroll themselves and their Dependents under the Plan.

The Plan Sponsor and Claims Administrator must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Plan Sponsor. The Plan Sponsor and Claims Administrator must receive the completed enrollment form and any required contribution within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Participants may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.

- Court or administrative order.
- Registering a Domestic Partner.
- Your eligible dependent moves to the United States. This is first time enrollment only. Re-entry to the United States after an extended leave outside of the United States is not a qualifying event for enrollment.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor and Claims Administrator must receive the completed enrollment form and any required contribution within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or

Open Enrollment Period and coverage under the prior plan ended because of any of the following:

- Loss of eligibility (including legal separation, divorce or death).
- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under Medicaid or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor and Claims Administrator receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor and Claims Administrator must receive the completed enrollment form and any required contribution within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor and Claims Administrator receive the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Late Enrollees for Medical Coverage

If the Claims Administrator receives your enrollment form after the applicable Initial Enrollment Period or a special enrollment period, you are a Late Enrollee (Refer to Section 14: *Glossary*). If you are a Late Enrollee, your enrollment may be postponed until the next Open Enrollment Period or a special enrollment period as described above.

SECTION 3- WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended.)

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**
  Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.
- **You Are No Longer Eligible**
  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to Section 14: *Glossary* for definitions of the terms "Eligible Person," "Participant," "Dependent" and "Enrolled Dependent."
- **The Claims Administrator Receives Notice to End Coverage**
  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.
- **Participant Retires or Is Pensioned**
  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the last day of the calendar month in which the Participant is retired or pensioned.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Participant that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as

a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental or physical disability.
- The Enrolled Dependent child depends mainly on the Participant for support.

Coverage will continue, as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage ends in accordance with the terms of the Plan.

You must furnish the Plan with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. The Plan will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan's request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation of coverage under the federal *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, as defined in Section 14: *Glossary*.

Continuation coverage under COBRA is available only to Plan Sponsors that are subject to the terms of COBRA. Contact your Plan Administrator to find out if Westmoor Country Club is subject to the provisions of COBRA.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a “Qualified Beneficiary”. A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant’s enrolled Dependent, including with respect to the Participant’s children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant’s former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Westmoor Country Club files for bankruptcy under Title 11, United States Code.	36 months	36 months	36 months

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the

Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide your Employer with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 14: *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Survivorship Benefit

In the event of your death while enrolled in the Plan, your Enrolled Dependent's health care coverage will continue as long as:

- You were covered at the time of your death;
- A request is made for the coverage to continue within 31 days of your death;
- If eligible for COBRA, this benefit runs concurrent with your COBRA benefit;
- Your coverage, at the time of your death, is not being continued after your employment had ended, as stated previously in this section *When Coverage Ends*;
- Payment is made for the coverage, Plan Sponsor contributions may no longer apply.

Your Dependent's coverage under the Plan will end on the earliest of:

- He or she becomes eligible for health benefits under this or any other group health plan including Medicare;
- The end of the 12 month period following your death;
- He or she no longer meets the definition of Dependent;
- The date the Spouse remarries;
- Any required contributions stop.

If your Dependent's coverage is being continued, a child born after your death will also be covered.

SECTION 4 - SCHEDULE OF BENEFITS

What this section includes:

- How Do You Access benefits?
- Prior Authorization requirements;
- Benefits;
- Annual deductible;
- Deductible carryover from prior carrier
- Out-of-Pocket Limit;
- Covered Health Care Services and;
- Provider network.

How Do You Access Benefits?

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Care Services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts as described in Section 14: *Glossary*.

Covered Health Care Services provided at certain Network facilities by an Out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described in Section 14: *Glossary*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under Allowed Amounts as described in Section 14: *Glossary*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under this plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the Network of providers and how your Benefits may be affected appears at the end of this Schedule of Benefits.

If there is a conflict between this Schedule of Benefits and any summaries provided to you by the Westmoor Country Club, this Schedule of Benefits will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

It is recommended that you confirm with the Claims Administrator that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are below within each Covered Health Care Service category.

Failure to obtain prior authorization will result in a reduction of benefits. Reduced benefits will be 50% of Allowed Amounts. Obtaining prior authorization does not guarantee payment. Please see the Prior Authorization provision for more information.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description below to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, the Plan urges you to confirm with Claims Administrator that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator’s final coverage determination will be changed to account for those differences, and the Plan will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid

Covered Health Care Services Which Require Prior Authorization

Ambulance, non-emergency

For Out-of-Network Benefits, you must obtain authorization for non-emergency ambulance transportation as soon as possible prior to transport.

Cellular and Gene Therapy

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Clinical Trials

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.

Diabetes Equipment

For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME, for the management and treatment of diabetes, that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

Durable Medical Equipment (DME), Orthotics and Supplies

For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

Gender Dysphoria

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

Home Health Care

For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving home health care services, or as soon as reasonably possible.

Hospice Care - Inpatient

For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility, or as soon as reasonably possible.

Hospital Inpatient Stay

For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled admission, or as soon as is reasonably possible for a non-scheduled admission (including emergency admissions).

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Lab, X-Ray and Diagnostic - Outpatient

For Out-of-Network Benefits, for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received; or for non-scheduled services, within one business day or as soon as is reasonably possible.

Major Diagnostic and Imaging

For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received, or for non-scheduled services, within one business day or as soon as is reasonably possible.

Maternity Services

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a caesarean section delivery.

Outpatient Surgery

For Out-of-Network Benefits for outpatient surgery, you must obtain prior authorization five business days before receiving scheduled services; or for non-scheduled services, within one business day or as soon as is reasonably possible.

Pharmaceutical Products

For Out-of-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible.

Prosthetic Devices

For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures, including breast reconstruction surgery following mastectomy

For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive surgery is performed; or for non-scheduled procedures, within one business day or as soon as is reasonably possible.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

Inpatient Rehabilitation Facility Services/Skilled Nursing Facility

For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before a scheduled admission; or as soon as is reasonably possible prior to a non-scheduled admission.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Therapeutic Treatments

For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization

requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments as secondary payer as described in Section 9: *Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Care Services.

Benefits

Benefits for Covered Health Care Services are described below.

Annual Deductibles are calculated on a Calendar Year basis.

Out-of-Pocket Limits are calculated on a Calendar Year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Annual Deductible

The Annual Deductible is the amount you must pay for Covered Health Care Services per Calendar Year before you are eligible to receive Benefits. There are separate Network and Out-of-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the Calendar Year. This Plan contains a family deductible which can be met by one family member or by a combination of family members. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this Schedule of Benefits.

The amount that is applied to the Annual Deductible is calculated on the basis of Allowed Amounts or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds Allowed Amounts. Details about the way in which Allowed Amounts are determined appear in the definition of "Allowed Amounts" in Section 14: *Glossary*.

The Annual Deductible does not include any applicable copayment.

	Network	***Out-of-Network***
Individual deductible	$4,000 per Covered Person per Calendar Year	$8,000 per Covered Person per Calendar Year
Family deductible	An aggregate of $8,000 of Allowed Amounts per Calendar Year	An aggregate of $16,000 of Allowed Amounts per Calendar Year

Deductible Carryover from Prior Carrier

If the Plan Sponsor terminated a prior medical plan with another carrier, and the Plan participant and any of their Dependents were covered by that prior plan on the day immediately prior to the date when the Plan participant's coverage under this plan became effective, then the plan will adjust the Calendar Year deductible under this plan as follows:

- the Deductible Amount under this plan will be credited to the extent that, expenses incurred under the prior plan had been applied against a similar deductible amount under that prior plan, even if the prior plan deductible amount had not been fully satisfied;
- Covered Health Care Services must apply to the deductible amount under this plan for the same Calendar Year that the Plan participant and their Dependents became effective under this plan.

All or part of the current Calendar Year deductible satisfied under the prior medical plan will be applied against the current deductible amount in this plan. Any amount of expenses incurred under the prior plan and in excess of the deductible amount in this plan will be denied.

Out-of-Pocket Limit

The Out-of-Pocket Limit is the maximum you pay per Calendar Year for the Annual Deductible, Copayments and Coinsurance. There are separate Network and Out-of-Network Out-of-Pocket Limits for this Plan. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that Calendar Year. The Out-of-Pocket Limit applies to Covered Health Care Services as indicated in this Schedule of Benefits, including Covered Health Care Services provided under Section 12: *Prescription Drug*.

Details about the way in which Allowed Amounts are determined appear in the definition of "Allowed Amounts" in Section 14: *Glossary*.

The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Care Services.
- The amount you are required to pay if you do not obtain prior authorization.
- Charges that exceed Allowed Amounts, when applicable.

	Network	***Out-of-Network***
Out-of-Pocket Limit	$8,150 per Covered Person, not to exceed $16,300 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.	$16,300 per Covered Person, not to exceed $32,600 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Copayment

Copayment (Copay) is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount listed is the Schedule of Benefits next to the description for each Covered Health Care Service.

Please note that the Covered Health Care Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Allowed Amount or the Recognized Amount when applicable.

Details about the way in which Allowed Amounts are determined are described in Section 14: *Glossary*.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.

Details about the way in which Allowed Amounts are determined are described in Section 14: *Glossary*.

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Acupuncture Services			
Limited to 10 visits per Calendar Year.	***Network*** $25	Yes	No
	Out-of-Network 50%	Yes	Yes
2. Ambulance Services			
Emergency Ambulance	***Network*** *Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described under the definition of Allowed Amounts in Section 14: *Glossary*	***Network*** *Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
	Out-of-Network *Ground Ambulance* 50%	Yes	Yes

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Air Ambulance Same as Network	Same as Network	Same as Network
3. Cellular and Gene Therapy			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
4. Chiropractic Treatment			
Limited to 20 visits of Chiropractic Treatment per Calendar Year.	***Network*** $25 ***Out-of-Network*** 50%	Yes Yes	No Yes
5. Clinical Trials			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each		

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Covered Health Care Service category in this Schedule of Benefits.		
6. Dental Services - Accident Only or Impacted Wisdom Teeth			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
7. Diabetes Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/ diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/ diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.		
8. Durable Medical Equipment (DME), Orthotics, Supplies and Ostomy Supplies			

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
9. Emergency Health Care Services - Outpatient			
Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in Section 14: *Glossary*.	***Network*** ***Physician*** 20%	Yes	Yes
	Facility 20% after you pay $300 and satisfy the annual deductible	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
10. Enteral Nutrition			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
11. Gender Dysphoria			
	Network		

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits		
12. Hearing Aids			
Note: For enrolled Dependent children under the age of 18: One hearing aid, per hearing impaired ear every 36 months. ***Note:*** Age 18 and over: Limited to $5,000 per Covered Person every 36 months.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
13. Home Health Care			
Limited to 30 visits per Calendar year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
14. Hospice Care			
	Network *Inpatient* 20% *Outpatient* 20% ***Out-of-Network*** *Inpatient* 50% *Outpatient* 50%	 Yes Yes Yes Yes	 Yes Yes Yes Yes
15. Hospital - Inpatient Stay			
	Network *Physician* 20% *Facility* 20% ***Out-of-Network*** *Physician* 50% *Facility* 50%	 Yes Yes Yes Yes	 Yes Yes Yes Yes
16. Lab, X-Ray and Diagnostic - Outpatient			
Limited to 18 Presumptive Drug Tests per year.	***Network*** *Physician*		

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Limited to 18 Definitive Drug Tests per year. ***Note***: This benefit does not include Lab, X-Ray, and other diagnostics performed as part of Emergency Health Care Services.	20% *Facility* 20% ***Out-of-Network*** *Physician* 50% *Facility* 50%	Yes Yes Yes Yes	Yes Yes Yes Yes
17. Major Diagnostic and Imaging - Outpatient			
	Network *Physician* 20% *Facility* 20% ***Out-of-Network*** *Physician* 50% *Facility* 50%	 Yes Yes Yes Yes	 Yes Yes Yes Yes
18. Maternity Services			

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Note: A Deductible will not apply for a newborn child with a length of stay in the Hospital the same as the mother's length of stay and the mother is covered on the plan.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.		
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
	Network *Inpatient Physician* 20%	Yes	Yes
	Outpatient Physician $75	Yes	No
	Inpatient Facility 20%	Yes	Yes
	Outpatient Facility 20%	Yes	Yes
	Partial Hospitalization/ Intensive Outpatient Treatment 20%	Yes	Yes
	Residential Treatment Facility - Limited to		

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	60 days per Calendar Year combined with Skilled Nursing Facility and Inpatient Rehabilitation Facility Limit. 20% ***Out-of-Network*** *Inpatient Physician* 50% *Outpatient Physician* 50% *Inpatient Facility* 50% *Outpatient Facility* 50% *Partial Hospitalization/ Intensive Outpatient Treatment* 50% *Residential Treatment Facility* - Limited to 60 days per Calendar Year combined with Skilled Nursing Facility and Inpatient Rehabilitation Facility Limit. 50%	Yes Yes Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes Yes Yes
20. Pharmaceutical Products			

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
21. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an Out-of-Network Physician in certain Network facilities will apply at the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider, however, Allowed Amounts will be determined as described under the definition of Allowed Amounts in Section 14: *Glossary*.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
22. Physician's Office Service - Sickness and Injury			
	Network **For Covered Persons under the age of 19:** None per visit for a Primary Care	Yes	No

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Physician office visit or $75 per visit for a Specialist office visit		
	For Covered Persons age 19 and older:	Yes	No
	$25 per visit for a Primary Care Physician office visit or $75 per visit for a Specialist office visit		
	Out-of-Network		
	For Covered Persons under the age of 19	Yes	Yes
	50%		
	For Covered Persons age 19 and older:	Yes	Yes
	50%		
23. Preventive Care Services			
Physician office services	***Network***		
	None	No	No
	Out-of-Network		
	50%	Yes	Yes
Lab, X-ray or other preventive tests	***Network***		
	None	No	No
	Out-of-Network		
	50%	Yes	Yes

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Breast pumps	***Network*** None ***Out-of-Network*** 50%	No Yes	No Yes
24. Prosthetic Devices			
	Network 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
25. Reconstructive Procedures			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.		
26. Rehabilitation and Habilitative Services			
Any combination of outpatient rehabilitation and habilitative services is limited to 30 visits per Calendar year.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
27. Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services			
Limited to 60 days per Calendar year combined with Residential Treatment Facility limit.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
28. Surgery - Outpatient			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
29. Therapeutic Treatments			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
30. Transplantation Services			
For Network Benefits, transplantation services must be received at a Designated Facility. The Claims Administrator does not require that cornea transplants be performed at a Designated Facility in order	***Network*** 20%	Yes	Yes

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
for you to receive Network Benefits. ***Note:*** The transplant network is different than the plan provider Network. Any transplant services outside of the Designated Facilities, including PPO providers and facilities, are considered out-of-network and NOT covered under the plan. To ensure Network Benefits, you must notify the Claims Administrator as soon as possibility of a transplant arises and before pre-transplantation evaluation. ***Note:*** Travel Expenses for a transplant are limited to $5,000 per transplant.	***Out-of-Network*** Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
31. Urgent Care Center Services			
One copayment applies between the physician and facility.	***Network*** ***Physician*** $50	Yes	No
	Facility $50	Yes	No
	Out-of-Network ***Physician*** 50%	Yes	Yes
	Facility 50%	Yes	Yes

Amounts which you are required to pay as shown below are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amount in Section 14: *Glossary*. The Allowed Amounts provision in the Section 14: *Glossary*, will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
32. Virtual Visits			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	**Network** None **Out-of-Network** Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.

Provider Network

The Claims Administrator of its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not the Employer's or the Claims Administrator's employees. It is your responsibility to choose your provider.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claim Administrator at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable

quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing an out-of-network Physician or health care facility, you may be eligible to receive Transition of Care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for Transition of Care Benefits, please contact the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claim Administrator's products. Refer to the provider online directory or contact the Claims Administrator for assistance.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or Out-of-Network Pharmacy and are subject to Copayments, Annual Deductibles, and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. If you use an Out-of-Network pharmacy, (including mail order), you may be responsible for any amount over the allowed amount.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service. Refer to Section 12: *Prescription Drug* for further coverage and exclusion information.

What Do You Pay?

You are responsible for paying the applicable Copayment, Annual Deductible and/or Coinsurance. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Deductible and Out-of-Pocket Limit.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible, Copayments and/or Coinsurance.

The amount you pay for the following under Section 12: *Prescription Drug* will not be included in calculating any Out-of-Pocket Limit:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Cost) will not be available to you.
- The difference between the Out-of-Network Reimbursement Rate and an Out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- Ancillary Charges.

An Ancillary Charge may apply when a covered prescription drug product is dispensed at your or the provider's request and there is another drug that is chemically the same available. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

Payment Information

Annual Deductible

The amount that is applied to the Annual Deductible is calculated on the basis of Allowed Amounts. The Annual Deductible does not include any amount that exceeds Allowed Amounts. The Annual Deductibles for Medical and Prescription Services are two separate deductibles and do not accumulate together.

Individual deductible	None
Family deductible	None

Copayment

Copayment for a Prescription Drug Product at a Network or Out-of-Network Pharmacy is a specific dollar amount.

Coinsurance

Coinsurance for a Prescription Drug Product at a Network or Out-of-Network Pharmacy is a percentage of the Prescription Drug Cost.

Copayment and Coinsurance

Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.

Special Programs: The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Variable Copayment Program: Certain specialty drugs may be subject to different Copayments and/or Coinsurance. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for a list of specialty medications available in this program.

NOTE: The tier placement of a Prescription Drug Product can change from time to time. These changes generally happen twice a year, but no more than six times per Calendar Year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment, Annual Deductible, and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Cost for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment, Annual Deductible, and/or Coinsurance.
- The Prescription Drug Cost for that Prescription Drug Product.

See the Copayments, Annual Deductible, and/or Coinsurance stated in the Benefit Information table for amounts.

NOTE: Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of Copayments, Annual Deductible, and/or Coinsurance.

Benefit Information

Prescription Drugs from a Retail Network or Out-of-Network Pharmacy

The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Applicable copayments are applied per 30-day supply.
- When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copayment, Annual Deductible, and/or Coinsurance that applies will reflect the number of days dispensed.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with the Claims Administrator. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

Your Copayment, Annual Deductible, and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product:

$10 copay

For a Tier-2 Prescription Drug Product:

$35 copay

For a Tier-3 Prescription Drug Product:

$75 copay

For a Tier-4 Prescription Drug Product:

$250 copay

Specialty Prescription Drug Products from a Preferred Specialty Network Pharmacy

The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Applicable copayments are applied per 30 day supply.
- When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copayment, Annual Deductible, and/or Coinsurance that applies will reflect the number of days dispensed.

Your Copayment, Annual Deductible, and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product:

$10 copay

For a Tier-2 Prescription Drug Product:

$35 copay

For a Tier-3 Prescription Drug Product:

$75 copay

For a Tier-4 Prescription Drug Product:

$500 copay

Non-Preferred Specialty Network Pharmacy is Not Covered.

Prescription Drug Products from a Mail Order Network or Out-of-Network Pharmacy

The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- You may be required to fill the first Prescription Drug Product order and get 1-3 refills through a retail pharmacy using a Mail Order Network or Out-of-Network Pharmacy.

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 mail order Copayment, Annual Deductible, and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

If the Prescription Drug Product is dispensed by a Mail Order out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with the Claims Administrator. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy

Your Copayment, Annual Deductible, and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product:

$25 copay

For a Tier-2 Prescription Drug Product:

$87.50 copay

For a Tier-3 Prescription Drug Product:

$187.50 copay

For a Tier-4 Prescription Drug Product:

$625 copay

SECTION 5- ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Care Services for which the Plan pays Benefits.

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in Section 14: *Glossary*)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in Section 3: *When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached Schedule of Benefits for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when covered Health Care Services are required, or
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

Chiropractic Treatment

Manipulative therapy and associated office visit to restore normal function to the nerve system and body structures including, but not limited to:

- Manipulation;
- Myofascial release; or
- Soft tissue mobilization.

Benefits are available for the cost to evaluate the need and extent of these therapies.

Benefits do not include:

- Maintenance care;
- Treatment and services for community re-entry;
- Supervised living;
- Residential living programs; or
- Work-hardening programs.

Clinical Trials

Routine patient care costs incurred while taking part 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 which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines, the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines, the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening when the Claims Administrator determines, the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and needed items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Investigational Service(s) or item,
  - The clinically appropriate monitoring of the effects of the item or service,
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and needed care arising from the receipt of an Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part 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. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It 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).* (Includes *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 the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - 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 takes place 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. It must have been approved by all relevant institutional review boards (IRBs) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Dental Services - Accident Only or Impacted Wisdom Teeth

Accident Only dental services when both of the following are true:

- Treatment is needed because of accidental damage;
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental happens due to normal activities of daily living or extraordinary use of the teeth is not considered an accident injury. Benefits are not available for repairs to teeth that are damaged due to such activities.

Dental services to repair damage caused by accidental Injury must follow these timeframes:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care); and
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination;
- Diagnostic X-rays;
- Endodontic (root canal) treatment;
- Temporary splinting of teeth;
- Prefabricated post and core;
- Simple minimal restorative procedures (fillings);
- Extractions;
- Post-traumatic crowns if such are the only clinically acceptable treatment; or
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

The Plan also covers dental care required for the direct treatment of an impacted wisdom tooth.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs.

Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies and Ostomy supplies.

Durable Medical Equipment (DME), Orthotics and Supplies and Ostomy Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the plan will pay only that amount that would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a walker, cane, or standard wheelchair.
- A standard hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD.

Benefits include lymphedema stockings for the arms as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include dedicated speech generating devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in Section 6: *Exclusions: What the Plan Will Not Cover*:

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this SPD.

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts;
- Irrigation sleeves, bags and catheters; and
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Emergency Health Care Services

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are not available for services to treat a condition that does not meet the definition of an Emergency.

Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietician.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated would result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician:

For the purpose of this Benefit "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the plan will pay only the amount that would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits for bone anchored hearing aids (BAHA) are a Covered Health Care Service for which Benefits are provided under the applicable medical/surgical benefit categories in the Summary Plan Description. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable Hearing Aid; or
- Hearing loss severe enough that it would not be remedied by a wearable Hearing Aid.

Benefits for BAHA are limited to one per Covered Person during the entire period of time the Covered Person is enrolled under the Plan and include repairs and/or replacement only if the BAHA malfunctions

Home Health Care

Services received from a Home Health Agency that all of the following:

- Ordered by a Physician; and
- Provided in your home by a registered nurse, therapist, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse, and
- Provided on a part-time Intermittent Care schedule.
- Provided when skilled care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the Terminally ill. It includes the following:

- Physical, psychological, social and spiritual care for the Terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay; and
- Room and board in a Semi-Private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*).

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Lab, X-ray and diagnostic services while inpatient confined are described under Hospital – Inpatient Stay.

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Major diagnostic and imaging services while inpatient confined are described under Hospital – Inpatient Stay.

Maternity Services

Benefits for Covered Health Care Services incurred by you or your Enrolled Dependent Spouse or daughter for a normal Pregnancy and for childbirth. Benefits include Covered Health Care Services for a cesarean section.

The plan will provide these Benefits on the same basis as they pay for Benefits for a Sickness, according to:

- Guidelines established by the American College of Obstetricians and Gynecologists; or
- Any other established professional medical association.

For inpatient care at a Hospital, the plan will provide Benefits for the mother for up to:

- 48 hours following a vaginal delivery; or
- 96 hours following an elective or scheduled cesarean section.

The mother is not required:

- To give birth in a Hospital; or
- To stay in the Hospital for these minimum hours.

The above hours do not prohibit the mother and her Physician from both deciding on an earlier discharge.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery happens outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital for the birth. A determination of whether to admit the mother to a Hospital for childbirth is made by the Physician.

For purposes of this provision, a Physician may be a person such as a nurse midwife or a physician assistant, who is:

- Licensed under applicable state law to provide maternity care;
- Directly responsible for providing maternity care to the mother; and
- Providing the care.

For purposes of this provision, a Hospital includes a licensed, free-standing birthing facility that provides services for:

- Prenatal care;
- Delivery;
- Immediate postpartum care; and
- Care of the child born at the center.

Covered Health Care Services incurred at a free standing birthing facility are provided on the same basis as maternity Benefits received at a Hospital. The same inpatient care time periods apply for maternity care received at a free standing birthing facility as for similar care received at a Hospital.

The plan will provide Benefits for Complications of Pregnancy the same as for a Sickness.

Follow-up Care

The plan will provide Benefits for Physician-directed follow-up care on the same basis as it pays for Benefits for a Sickness.

Follow-up care services include:

- Physical assessment of the mother and newborn;
- Parent education;
- Help and training in breast or bottle feeding;
- Assessment of the home support system;
- Performance of any Medically Necessary and appropriate clinical tests; and
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Benefits apply to services provided in a medical setting or through home health care visits. Benefits apply to a home health care visit only if the health care provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When the mother and her Physician decide to shorten the length of the Inpatient Stay to less than the number of hours required under this maternity benefit and the newborn well baby care benefit, the plan will provide Benefits for all follow-up care that is provided within 72 hours after discharge.

When the mother or newborn receives at least the number of hours of inpatient care required to be covered, the plan will only provide Benefits for follow-up care that is determined to be Medically Necessary by the health care provider responsible for discharging the mother or newborn.

Newborn Well Baby Care

Benefits for newborn well baby care are provided on the same basis as Benefits for a Sickness.

The plan will provide Benefits for newborn well baby care that meets the definition of a preventive care service.

The plan will provide Benefits for newborn well baby care according to:

- Guidelines established by the American Academy of Pediatrics; or
- Any other established professional medical association.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital on its own behalf;
- Physician charges for circumcision; and
- Physician charges for the first routine exam of the child before discharge from the Hospital.

The plan will provide Benefits for newborn well baby care for up to:

- 48 hours of the child's life for a vaginal delivery; or
- 96 hours of the child's life for a cesarean section,

However, the plan will never provide benefits for newborn well baby care after the mother is discharged from the Hospital.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery.

These are federally mandated requirements under the Newborn's and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

If delivery happens outside of a Hospital, the 48 or 96 hours begin when the newborn is admitted to the Hospital for the birth. A determination of whether to admit the newborn to a Hospital is made by the Physician.

For purposes of this provision, a Physician is a person who is:

- Licensed under applicable state law to provide pediatric care;
- Directly responsible for providing pediatric care to the child; and
- Providing the care.

IMPORTANT: To provide coverage for the child, (Including Newborn Well Baby Care), you must enroll the child under the plan as required under adding new dependents in Section 2: *When Coverage Begins* sub-section *When Do You Enroll and When Does Coverage Begin?* Failure to enroll will result in no coverage for the newborn under this plan.

Mental Health Care and Substance Related and Addictive Disorder Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment Facility.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.

- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavioral Analysis (ABA) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a Board Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this Summary Plan Description.

The Plan determines coverage for all levels of care. If an Inpatient Stay or Residential Treatment is required, it is covered on a Semi-Private Room basis (a room with two or more beds).

Pharmaceutical Products

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in the Summary Plan Description. Benefits for medication normally available by a prescription order or refill are provided as described under your Outpatient Prescription Drug Benefit.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, the Claims Administrator may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, benefits are not available for that Pharmaceutical Product.

Physician Fees for Surgical Services and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment; and
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for Preventive Care provided in a Physician's office are described under Preventive Care Services.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient*.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital 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 an A or B rating in current recommendations of the United States preventive Services Task Force;
- Immunizations that have in effect a recommended by 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 for infants, children, and adolescents as provided for in the comprehensive guidelines supports by the *Health Resources and Services Administration (HRSA)*; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

    Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician.

    If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

    - Which pump is the most cost effective.
    - Whether the pump should be purchased or rented (and the duration of any rental).
    - Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands;
- Artificial face, eyes, ears and noses;
- Speech aid prosthetics and trachea-esophageal voice prosthetics; and
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under Durable Medical Equipment (DME), Orthotics, Supplies and Ostomy Supplies.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this Summary Plan Description.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition, or
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior due to an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Note: Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications are provided in the same manner and at the same level as those for any other Covered Health Care Service.

Rehabilitation and Habilitative Services - Outpatient Therapy

Short-term outpatient rehabilitation services, including habilitative services, limited to:

- Physical therapy;
- Occupational therapy;

- Speech therapy;
- Pulmonary rehabilitation therapy;
- Cardiac rehabilitation therapy; and
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services, or
- Rehabilitation goals have previously been met.

For outpatient rehabilitative services for speech therapy, the plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, or Physician.
- Treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider expects that continued treatment is or will be required to allow you to achieve progress this is capable of being demonstrated, the Claims Administrator may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, expected duration of treatment, the expected goals of treatment, and how frequently the treatment plan will be updated.

Habilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a part of habilitative services, are described under Durable Medical Equipment and *Prosthetic Devices*.

Other than as described under *Habilitative Services* above, please note that the plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly. The plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay; and
- Room and board in a Semi-Private Room
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient Facility

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy,
- Laparoscopy,

- Bronchoscopy,
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits under this provision include the facility charge and the charge for supplies and equipment.

Therapeutic Treatments

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment;
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include the facility charge and the charge for related supplies and equipment.

Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational Service or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, double lung, kidney, kidney/pancreas, liver, liver/small intestine, pancreas, bowel, small intestine and cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Plan, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

If you are required to receive transplantation services at a Designated Facility outside your geographic area, the plan will provide travel and lodging in agreement with the Claims Administrator's guidelines.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in an urgent care clinic setting. Benefits are available as described under Physician's visit - Sickness and Injury.

When a test is performed or a sample is drawn in the urgent care center, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, are described under Lab, X-ray and Diagnostic - Outpatient.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Major Diagnostic and Imaging - Outpatient.

Virtual Visits

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio with video technology or audio only outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email or fax, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

SECTION 6 - EXCLUSIONS: WHAT THE PLAN WILL NOT COVER

What this section includes:

- How Are Headings Used in this Section?
- Plan Does not Pay Benefits for Exclusions.
- Where are Benefits Limitations Shown?
- Services, supplies and treatments that are not Covered Health Care Services, except as may be specifically provided for in Section 5: *Additional Coverage Details*.

How Are Headings Used in this Section

To help you find exclusions, this section contains headings (for example A. Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in Section 5: *Additional Coverage Details* or through an Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Services categories described in Section 5: *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Care Service category in Section 4: *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in Section 4: *Schedule of Benefits*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not the intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

- Acupressure
- Aromatherapy;

- Hypnotism;
- Massage therapy (This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 5: *Additional Coverage Details*.);
- Rolfing (holistic tissue massage);
- Adventure based therapy, wilderness therapy and outdoor therapy, or similar programs; and
- Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 5: *Additional Coverage Details*.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Impacted Wisdom Teeth in Section 5: *Additional Coverage Details*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation;
- Prior to the initiation of immunosuppressive drugs; and
- The direct treatment of cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not needed to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or due to medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- removal, restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Impacted Wisdom Teeth in Section 5: *Additional Coverage Details*.

Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Impacted Wisdom Teeth in Section 5: *Additional Coverage Details*.

Dental braces (orthodontics).

Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

- Devices used as safety items or to help performance in sports-related activities.
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over the counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics, Supplies and Ostomy Supplies in Section 5: *Additional Coverage Details*.
- The following items are excluded, even if prescribed by a Physician:
  - blood pressure cuff/monitor.
  - enuresis alarm.
  - non-wearable external defibrillator.
  - Trusses.
  - ultrasonic nebulizers.
- Devices and computers to help in communication and speech except for dedicated speech generating devices and trachea-esophageal voice prosthetics for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in Section 5: *Additional Coverage Details*.
- Oral appliances for snoring.
- Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered and non-powered exoskeleton devices.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 12: *Prescription Drugs*, for coverage details and exclusions.

- Prescription drug products for outpatient use that are filled by a prescription order or refill.
- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (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 certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-infusion.

- Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
- Over-the-counter drugs and treatments.
- Certain new Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in Section 5: *Additional Coverage Details*.
- A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
- Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
- Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 5: *Additional Coverage Details*.

Foot Care

- Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 5: *Additional Coverage Details*.
- Nail trimming, cutting, or debriding. This exclusion does not apply to preventive care for Covered Persons who are at risk of neurological vascular disease arising from disease such as diabetes.
- Hygienic and preventive maintenance foot care. Examples include:
  - cleaning and soaking the feet; and
  - applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological and neurological and vascular disease arising from diseases such as diabetes.

- Shoes
- Shoe orthotics;
- Shoe inserts; and
- Arch supports.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.

- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction, reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Mental Health Care and Substance-Related and Addictive Services

In addition to all other exclusions listed in this Section 6: *Exclusions: What the Plan Will not Cover*, the exclusions listed directly below apply to services described under Mental Health Care and Substance-Related and Addictive Services in Section 5: *Additional Coverage Details*.

- Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
- Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Transitional Living Services.
- Non-Medical 24-Hour Withdrawal Management.
- High intensity residential care, including *American Society of Addiction Medicine (ASAM)* Criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

- Individual and group nutritional counseling including nonspecific nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by

appropriately licensed or registered health care professionals when both of the following are true:

- nutritional education is required for a disease in which patient self-management is an important part of treatment; and
- there is a lack of knowledge regarding the disease which requires the help of a trained health professional.

- Food of any kind including infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 5: *Additional Coverage Details*.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

- Television;
- Telephone;
- Beauty/barber service;
- Guest service; and

- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers;
  - Batteries and battery chargers;
  - Car seats;
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;
  - Electric scooters;
  - Exercise equipment;
  - Home modifications such as elevators, handrails and ramps;
  - Hot tubs;
  - Humidifiers;
  - Jacuzzis;
  - Mattresses;
  - Medical alert systems;
  - Motorized beds;
  - Music devices;
  - Personal computers;
  - Pillows;
  - Power-operated vehicles;
  - Radios;
  - Saunas;
  - Stair lifts and stair glides;
  - Strollers;
  - Safety equipment;
  - Speech generating devices;
  - Treadmills;
  - Vehicle modifications such as van lifts;
  - Video players; and
  - Whirlpools.

Physical Appearance

- Cosmetic Procedures. See the definition in Section 14: *Glossary*. Examples include:
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
  - Pharmacological regimens, nutritional procedures or treatments;
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures;
  - Skin abrasion procedures performed as a treatment for acne;
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin;
  - Treatment for spider veins;
  - Sclerotherapy treatment of veins; and
  - Hair removal or replacement by any means.
- Breast implants or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 5: *Additional Coverage Details*.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs regardless of the reason for the hair loss

Procedures and Treatments

- Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
- Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
- Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
- Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
- Biofeedback.

- Services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.
- Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
- Surgical and non-surgical treatment of obesity.
- Stand-alone multi-disciplinary smoking cessation programs.
- Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under Reconstructive Procedures in Section 5: *Additional Coverage Details*.
- Helicobacter pylori (H. pylori) serologic testing.
- Intracellular micronutrient testing.

Providers

- Services performed by a provider who is a family member by birth or marriage. Examples include a Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal address.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.
- This exclusion does not apply to mammography.

Reproduction

- Health Care Services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

- The following services related to Gestational Carrier or Surrogate:
  - All costs related to reproductive techniques including:
    - Assistive reproductive technology;
    - Artificial insemination;
    - Intrauterine insemination; and
    - Obtaining and transferring embryo(s).
  - All fees including:
    - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees;
    - Surrogate insurance premiums; and
    - Travel or transportation fees.
  - Health care services including: (This exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.)
    - Inpatient or outpatient prenatal care and/or preventive care;
    - Screenings and/or diagnostic testing; and
    - Delivery and post-natal care.
- Cost of donor eggs and donor sperm.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
- The reversal of voluntary sterilization.
- Health Care Services and related expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to:
  - Treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
  - Is necessary to save the life of the woman.
  - Is Necessary to avert substantial and irreversible impairment of a major bodily function.
  - A fetus that has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal, or
  - When the Pregnancy is the result of rape or incest.
- In vitro fertilization regardless of the reason for treatment.

Services Provided under another Plan

- Health Care Services for when other coverage is required by federal, state or local law to be purchased or bought through other arrangements. Examples include coverage required by workers' compensation or similar legislation.

  If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury,

Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
- Health Care Services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health Care Services while on active military duty.

Transplants

- Health Care Services for organ and tissue transplants, except those described under Transplantation Services in Section 5: *Additional Coverage Details*.
- Health Care Services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
- Health Care Services for transplants involving animal organs.
- Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel

- Health Care Services provided in a foreign country, unless required as Emergency Health Care Services.
- Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to ambulance transportation or to travel for transplantation services as described in Section 5: *Additional Coverage Details*.

Types of Care

- Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
- Custodial Care or maintenance care.
- Domiciliary care.
- Private duty nursing.
- Respite care.
- Rest cures.
- Services of personal care aides.
- Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision

- Cost and fitting charge for eye glasses and contact lenses.
- Routine vision exams, including refractive exams to determine the need for vision correction.

- Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
- Eye exercise therapy or vision therapy.
- Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

- Health Care Services and supplies that do not meet the definition of a Covered Health Care Service Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determine to be all of the following:
  - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
  - Medically Necessary.
  - Described as a Covered Health Care Service in this Summary Plan Description under Section 5: *Additional Coverage Details* and in the *Schedule of Benefits*.
  - Not otherwise excluded in this Summary Plan Description under Section 6: *Exclusions: What the Plan Will Not Cover*.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required only for career, school, sports or camp, travel, employment, insurance, marriage or adoption;
  - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
  - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 5: *Additional Coverage Details*.
  - Required to obtain or maintain a license of any type.
- Health Care Services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Care Services if they are to treat complications that arise from the non-Covered Health Care Service.

  For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
- Health Care Services received after the date your coverage under the Plan ends. This applies to all Health Care Services, even if the Health Care Service is required to treat a medical condition that arose before the date your coverage under the Plan ended.
- Health Care Services received due to war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

- Health Care Services for which you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
- In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance any deductible, or other amount owed for a particular Health Care Service, no Benefits are provided for the Health Care Service for which the Copayments, Coinsurance and/or deductible are waived.
- Charges in excess of Allowed Amounts, when applicable, or in excess of any specified limitation.
- Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
- Autopsy.
- Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

SECTION 7- HOW TO FILE A CLAIM

What this section includes:

- Claims mailing address
- How are Covered Health Care Services from a Network Provider Paid?
- How are Covered Health Care Services from an Out-of-Network Provider Paid?
- Notice of claim
- Claim forms
- Proof of loss
- Payment of claim
- Time of payment of claim
- Assignment of benefits

Claims Mailing Address

Level Funded

PO Box 31394

Salt Lake City, UT 84131

How Are Covered Health Care Services from Network Providers Paid?

The Claims Administrator processes payment to Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact the Claims Administrator. However, you are required to meet any applicable Annual Deductible and to pay any required Copayments and Coinsurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you or the out-of-Network provider is responsible for requesting payment from the Claims Administrator.

You or the out-of-Network provider should submit a request for payment of Benefits within 90 days after the date of service. If you or the out-of-Network provider do not provide this information to the Claims Administrator within 15 months of the date of service, Benefits for that health service will be denied or reduced, as the Claims Administrator determines. This time limit does not apply if you are legally incapacitated or if extenuating circumstances apply. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Participant's name and address.

- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with the Claims Administrator at the address on your ID card.

Proof of Loss

The Plan requires written proof of loss. A written proof of loss is a bill from a health care provider. The Plan must receive the proof within 90 days from the date of loss.

Failure to send the proof of loss in that time does not invalidate or reduce a claim if you can show that it was not reasonably possible to send proof of loss in that time, and you sent it when reasonably possible.

In any event, the Claims Administrator must receive the proof of loss not later than 15 months from the date of loss, unless you are not legally competent to send it during that time.

Payment of Benefits

The Plan has the authority to automatically pay Benefits to Physicians or other providers. After the plan pays, they are discharged from paying any further Benefits to the extent of what it has already paid.

If you want to receive direct payment of Benefits, you must notify the Claims Administrator before they receive proof of loss; except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an out-of-Network provider.

The Plan may be required to pay Benefits to your estate, to your Dependent's estate, or to someone who is a minor or is otherwise not legally competent. When this happens, the Plan may pay an amount not to exceed $1,000 to a family member who it believes is equitably entitled to that amount. Any payment made in good faith fully discharges the Plan, to the extent of that payment.

If the Claims Administrator has documented proof that:

- A Physician or other provider waived from their total fees a Copayment, Annual Deductible or Coinsurance amount that you are otherwise required to pay under the plan; then
- The Plan has the right to reduce the benefit amount the plan pays by the amounts waived by the Physician or other provider.

If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of

the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 9: *Coordination of Benefits*.

Time of Payment of Claim

The plan will pay or deny a claim when a claim is received that includes all of the information needed to process.

If additional supporting information is required to process the claim, the Plan will notify the applicable person(s). This notice will detail the supporting documentation needed.

As applicable, the provider or both you and the provider will be notified when a claim is denied. The notification will include the reason(s) for the denial.

SECTION 8 - QUESTIONS, COMPLAINTS AND APPEALS

What this section includes:

- What if You Have a Question?;
- What if You have a Complaint?;
- How Do You Appeal a Claim Decision?;
- Appeal process;
- Appeals Determinations;
- Urgent appeals that require immediate action;
- Federal external review program;
- Standard external review;
- Expedited external review; and
- Appeals of other than adverse benefit determinations.

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Plan in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Plan will notify you of their decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Plan in writing to request an appeal.

For non-urgent appeals, you may contact the Plan at:

Grievance Administrator

PO Box 31393

Salt Lake City, UT 84131

Fax: 801-478-5463

Phone: 877-797-8812

If you feel your situation is urgent, you may request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator

PO Box 19032

Green Bay, WI 54307

Fax: 877-220-7537

Phone: 877-797-8812

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be review the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. Any new or additional evidence is relied upon or generated by the Plan during the determination of the appeal, will be provided to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

For appeals of pre-service requests for Benefits you will be notified of the decision within 15 days from receipt of a request for a first level appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. You will be notified of the decision within 15 days from receipt of a request for review of the second level appeal decision.

For appeals of post-service claims you will be notified of the decision within 30 days from receipt of a request for a first level appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. You will be notified of the decision within 30 days from receipt of a request for review of the second level appeal decision.

Please note that the Plan's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Plan's decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain.

In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.

The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Claims Administrator
- The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization *(*IRO*)*. The Claims Administrator has entered into agreements with three or more IRO*s* that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the IRO.
- A decision by the IRO.

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator

will assign as IRO to conduct such review. The Claims Administrator will assign requests by either rotating among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination.

The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the Claims Administrator receives a Final External Review Decision reversing the Claims Administrator's determination, coverage or payment for the Benefit claim at issue will be provided according to the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with the Claims Administrator's determination, Benefits for the health care service or procedure will not be provided.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function.
  - If you have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
  - Involves a medical condition where the timeframe completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
  - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator used to assign standard external reviews to IRO*s*. The Claims Administrator will provide documents and information used in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's final external review decision is first communicated verbally, the IRO will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits- a request for Benefits provided in connection with urgent care services.
- Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify Claims Administrator before non-urgent care is provided.
- Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and Claims Administrator are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to Claims Administrator within:	48 hours after receiving notice of additional information required
Claims Administrator must notify you of the benefit determination after receiving additional information within:	48 hours of receipt of the information or the end of the period provided to provide the additional information
Claims Administrator must notify you of the benefit determination within:	72 hours
If Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to Claims Administrator within:	45 days
Claims Administrator must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	15 days
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Claims Administrator must notify you of the second level appeal decision within:	15 days after receiving the second level appeal*

*Claims Administrator may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, Claims Administrator must notify you within:	30 days
You must then provide completed claim information to Claims Administrator within:	45 days
Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Claims Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal*

*Claims Administrator may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Appeals of Other Than Adverse Benefit Determinations

If you or your authorized representative disagree with a determination other than those described under the procedures above, you or your authorized representative may ask to have it reviewed.

A written request should be sent to the Claims Administrator within 180 calendar days of the date you or your authorized representative receive the adverse determination. The appeal may include:

- written comments, documents, records, and other information relating to the determination; and

- the ID numbers on your insured ID card.

Please state the reason(s) you or your authorized representative disagree with the determination and include all information that may support the appeal.

The Claims Administrator will notify you or your authorized representative of the decision within 30 days of the Claims Administrator's receipt of the appeal request. If the Claims Administrator denies your first appeal, a second appeal may be requested using the same procedures as required for the first. The Claims Administrator will respond to the second appeal within 30 days of the Claims Administrator's receipt of the second appeal request; this completion of the second appeal will exhaust the appeal process.

SECTION 9 - COORDINATION OF BENEFITS (COB)

What this section includes:

- Benefits When You Have Coverage under More than One Plan
- Definitions
- What Are the Rules for Determining the Order of Benefit Payments?
- How Are Benefits Paid When This Plan is Secondary to Medicare?

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Does Coordination of Benefits Apply?

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies;

Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan**. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense**. For the purposes of COB, an Allowable Expense is a health care expense, including deductibles, coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

When the provider is a Network provider for both the primary plan and this Plan, the Allowable Expense is the primary plan's network rate. When the provider is a network provider for the primary plan and an out-of-Network provider for this Plan, the Allowable Expense is the primary plan's network rate. When the provider is an out-of-Network provider for the primary plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the primary plan. When the provider is an out-of-Network provider for both the primary plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess

of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include precertification of admissions and preferred provider arrangements.

E. Closed Panel Plan. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;

C. A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;

D. If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

E. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

F. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary

coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

G. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

H. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, participant or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, participant or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court decree states that one of the parents is responsible for the dependent child's health or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the

provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled H.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, participant or retiree or covering the person as a dependent of an employee, member, participant or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled H.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining

the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and this Plan is secondary to Medicare, this Plan will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, the Claims Administrator may, as the Claims Administrator determines, treat

the provider’s billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

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 Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Claims Administrator may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments made 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 paid or for whom the Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowable Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of you, you, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan’s obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.

- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

SECTION 10 - SUBROGATION AND REIMBURSEMENT; RETURN OF OVERPAYMENTS

What this section includes:

- Right of recovery;
- Right to subrogation;
- Right to reimbursement;
- Third parties;
- Subrogation and reimbursement provisions; and
- Refund of overpayments.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the Calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Limit for the Calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Limit for the Calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you or your dependents may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid benefits on your or your

dependents behalf for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your or your dependents behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you or your dependents receive a settlement, judgment, or other recovery from any third party, you or your dependents must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you or your dependent to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- Westmoor Country Club in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you or your dependent with benefits or payments under:
- underinsured or uninsured motorist insurance;
- medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
- workers' compensation coverage; or
- any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's 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 you recover from a third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall 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 shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- 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 may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- in case of your 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.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, 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 Sickness or Injury 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 a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

Refund of Overpayments

If Westmoor Country Club pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Westmoor Country Club if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Westmoor Country Club made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount Westmoor Country Club paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help Westmoor Country Club get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Westmoor Country Club may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Westmoor Country Club may have other rights in addition to the right to reduce future Benefits.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with the Claims Administrator and Westmoor Country Club.
- Relationships with Providers and Plan Sponsors.
- Interpretation of Benefits.
- Information and records.
- Incentives to Providers and you.
- Rebates and other payments.
- Workers' compensation not affected.
- The future of the Plan.
- Plan document.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Claims Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

What is Your Relationship with the Claims Administrator and Westmoor Country Club?

In order to make choices about your health care coverage and treatment, Westmoor Country Club believes that it is important for you to understand how the Claims Administrator interacts with the Plan Sponsor's benefit Plan and how it may affect you. The Claims Administrator helps administer the Plan Sponsor's benefit plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this SPD.
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Westmoor Country Club and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Westmoor Country Club and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in operations and in

research. Westmoor Country Club and the Claims Administrator will use de-identified data for commercial purposes including research.

What is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The Claims Administrator has agreements in place that govern the relationships between it and Westmoor Country Club and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Care Services to Covered Persons.

Westmoor Country Club and the Claims Administrator do not provide health care services or supplies, or practice medicine. Westmoor Country Club and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The network's credentialing process utilized by the Claims Administrator or its affiliates confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not Westmoor Country Club's employees. Network providers are not the Claims Administrator's employees. Westmoor Country Club and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan.

Westmoor Country Club is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee and premium to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

What is Your Relationship with Providers and Plan Sponsors?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Allowed Amounts, when applicable.
- Paying, directly to your provider, the cost of any non–Covered Health Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Westmoor Country Club is that of employer and employee. Dependent or other classification as defined in the SPD.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participants and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Participants

All statements made by the Plan Sponsor or by a Participant shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Who Interprets Benefits and Other Provisions under the Plan?

Westmoor Country Club and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this SPD, the Schedule of Benefits and any Addendums, Riders and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Westmoor Country Club and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Westmoor Country Club may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that Westmoor Country Club does so in any particular case shall not in any way be deemed to require Westmoor Country Club to do so in other similar cases.

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims

Administrator may also use de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. The Claims Administrator agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, The Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de–identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, the Claims Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights as the Claims Administrator has.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - A group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-

up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have any questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs, and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at the number on the back of your ID card if you have any questions.

Hospital and Medical Bill Audit Benefit

This benefit provides you with a cash incentive for discovering and reporting to the Claims Administrator overcharges made on your hospital or other medical bills. The benefit works as follows:

- For purposes of this benefit, only overcharges made for covered services are considered. Charges for telephone, television, newspaper, etc. are not included.
- You must send the Claims Administrator a copy of the itemized bill and indicate on it by circling the overcharge items. The Claims Administrator will review the overcharges with the hospital or other provider.
- If the hospital or provider agrees to reduce its billing by the overcharges, the Plan will pay direct to you 50% of the savings up to a $1,000 benefit per Calendar year. No payment will be made if the total overcharges on a bill are less than $10.

Does the Claims Administrator Receive Rebates and Other Payments?

Westmoor Country Club and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your applicable deductible. Westmoor Country Club and the Claims Administrator may pass these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

Is Workers' Compensation Not Affected?

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

What is the Future of the Plan?

Although Westmoor Country Club expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

Westmoor Country Club's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If Westmoor Country Club does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

When Does the Plan Receive Refunds of Overpayments?

If the Plan pays Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to the Plan if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

Amendments to the Plan

To the extent permitted by law, the Claims Administrator has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan’s next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in Section 8: *Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

SECTION 12 - Prescription Drug

What this section includes:

- Coverage policies and guidelines
- Identification card (ID Card) - Network Pharmacy
- When Does the Claims Administrator Limit Selection of Pharmacies?
- Benefits for prescription drug products
- What Happens When a Brand name Drug Becomes Available as a Generic?
- How Do Supply Limits Apply?
- Special Programs
- Prior Authorization Requirements
- Specialty Prescription Drug Products
- Does Step Therapy Apply?
- Rebates and other payments
- Coupons, Incentives and Other Communications
- Variable Copayment Program
- Exclusions

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include, review of the place in therapy, or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if supply limits or notification requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions than others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Claims Administrator may from time to time change the placement of a Prescription Drug Product among the tiers. These changes generally will happen twice a year, but no more than six times per Calendar Year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

Note: The tier placement of a Prescription Drug Product may change from time to time based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

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

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may pay more if you did not verify your eligibility when the Prescription Drug Product was dispensed or when you utilize an out-of-network pharmacy. You may be required to submit your claim to the pharmacy address on the back of your ID card. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

When Does the Claims Administrator Limit Selection of Pharmacies?

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will choose a single Network Pharmacy for you.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy or an Out-of-Network Pharmacy and are subject to Copayments, Annual Deductibles, and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Section 4: *Schedule of Benefits* for applicable Copayments, Annual Deductible, and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Prescription Drugs from a Retail Network or Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network or Out-of-Network Pharmacy.

Refer to Section 4: *Schedule of Benefits* for details on retail Network or Out-of-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network or Out-of-Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network or Out-of-Network Pharmacy.

Refer to the Section 4: *Schedule of Benefits* for details on mail order Network or Out-of-Network Pharmacy supply limits.

The Outpatient Prescription Drug benefit offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

Please access the Claims Administrator's website through www.myuhc.com or call the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand- name Prescription Drug Product may change. Therefore your Copayment, Annual Deductible, and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-Name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the Benefit Information section. For a single Copayment and/or Coinsurance, after deductible if applicable, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that have been developed. Supply limits are subject from time to time to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Special Programs

There may be certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization. The reason for obtaining prior authorization is to determine if the Prescription Drug Product is eligible for coverage. Medical Necessity goes beyond drug and diagnosis and takes into consideration the clinical appropriateness of a medication in terms of condition being treated, severity of conditions,

type of medication, frequency of use, and duration of therapy. You may determine whether a Prescription Drug Product requires prior authorization by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

Does Step Therapy Apply?

In order to receive benefits for a Prescription Drug Product subject to step therapy requirements, the Claims Administrator may require that your doctor first prescribe another Prescription Drug Product proven to be effective for treatment of your condition. You may determine whether a particular Prescription Drug Product or pharmaceutical product is subject to step therapy requirements by calling the phone number on your identification card.

Rebates and Other Payments

The Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List. As determined by the Claims Administrator, the Claims Administrator may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Deductible, Copayment and/or Coinsurance.

The Claims Administrator, and a number of the Claims Administrator's affiliated entities, conduct business with pharmaceutical manufacturers. 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 Benefit. the Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, the Claims Administrator may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. Pharmaceutical manufacturers or an affiliate may pay for and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Variable Copayment Program

Certain specialty medications are eligible for Copayment assistance by drug manufacturers. The Claims Administrator may help you determine whether your specialty medication is eligible for Copayment assistance. If you receive Copayment assistance from a drug manufacturer, your Copayment and/or Coinsurance may vary. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for a list of specialty medications available in this program.

Amounts paid by drug manufacturers toward cost sharing will not count toward any deductible that applies or Out-of-Pocket Limit.

Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this section. The following will not be considered Covered Health Care Services, and Benefits will not be available under this section for the following:

- Prescription Drug Products obtained from an Out-of-Network Pharmacy;
- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment;
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay;
- Experimental or Investigational Services or Unproven Services and medications; medications used for experimental treatments for specific disease and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products that have been approved by the U.S. Food and Drug Administration (FDA), but have not been approved by the FDA to be lawfully marketed for the proposed use, if the Prescription Drug Product has been recognized as safe and effective for treatment of a particular indication in one or more of the publications or literature listed below:
  - The AMA Drug Evaluations, a publication of the American Medical Association;
  - The AHFS (American Hospital Formulary Service) Drug Information, a publication of the American Society of Health System Pharmacists;
  - Drug Information for the Health Care Provider, a publication of the United States Pharmacopoeia Convention; or
  - medical literature may be accepted in place of the above compendia if all of the following apply:
    - two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
    - no article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; and
    - each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the United States Department of Health and Human Services as accepted peer-reviewed medical literature;
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent 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;
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness 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 product dispensed for the purpose of appetite suppression or weight loss;
- A Pharmaceutical Product for which Benefits are provided in your Summary Plan Description;
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies. This exclusion does not apply to diabetic supplies and inhaler spacers specifically stated as covered;
- General vitamins, except the following which require a Prescription Order or Refill:
  - Prenatal vitamins
  - Vitamins with fluoride
  - Single entity vitamins
- Unit dose packaging of Prescription Drug Products;
- Medications used for cosmetic purposes;
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service;
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed;
- Prescription Drug Products when prescribed to treat infertility;
- Treatment for toenail onychomycosis (toenail fungus);
- Certain prescription Drug Products for tobacco cessation;
- Diagnostic kits and products;
- Dental products, including but not limited to prescription fluoride topicals;
- Prescription Drug Products not placed on Tier-1, Tier-2, Tier-3, or Tier-4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed;
- Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3;
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a Calendar Year, and the Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

- New Prescription Drug Products and/or new dosage forms until the date they are placed on a tier by the Claims Administrator's Prescription Drug List Management Committee;
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill;
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury;
- A Prescription Drug Product that contains marijuana, including medical marijuana;
- New Pharmaceutical Products and/or new dosage forms until the date they are reviewed by the Claims Administrator.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product;
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product;
- A Prescription Drug Product with either:

  An approved biosimilar

  A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product

  For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

  It is highly similar to a reference product (a biological Prescription Drug Product)

  It has no clinically meaningful differences in terms of safety and effectiveness from the reference product

  Such determinations may be made up to six times per calendar year.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Claims Administrator in writing or call the toll-free number on your ID card. We will notify you of the Claims Administrator's determination within 72 hours.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call the Claims Administrator as soon as possible. The Claims Administrator will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by calling the toll-free number on your ID card. The Independent Review Organization (IRO) will notify you of the Claims Administrator's determination within 72 business hours.

Expedited External Review

If you are not satisfied with the Claims Administrator's determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card. The IRO will notify you of the Claims Administrator's determination within 24 business hours.

SECTION 13 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 14: *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Westmoor Country Club is the Plan Sponsor and Plan Administrator of the Westmoor Country Club Welfare Benefit Plan and has the authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan

Westmoor Country Club

400 S MOORLAND RD

BROOKFIELD, WI 53005

262-796-7800

Claims Administrator

United Healthcare Services, Inc., or its affiliates or designee is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative services agreement with the Westmoor Country Club. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.

PO Box 19032

Green Bay, WI 54307-9032

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan

Westmoor Country Club

400 S MOORLAND RD

BROOKFIELD, WI 53005

262-796-7800

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by *ERISA*.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Westmoor Country Club Health Benefit Plan
Plan Number:	501
Employer ID:	390701670
Plan Type:	Welfare benefits plan
Plan Year:	April 01, 2022 - March 31, 2023
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents - including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided in Section 8: *Questions, Complaints and Appeals*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, *ERISA* imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under *ERISA*.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 8: *Questions, Complaints and Appeals*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by Westmoor Country Club, the Plan Administrator. The Claims Administrator, United Healthcare Services, Inc. or its affiliate or designee is the Claims Administrator and processes claims for the Plan and provides appeal services; however, the Claims Administrator and Westmoor Country Club are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or Out-of-Network provider. The Claims Administrator and Westmoor Country Club are neither liable nor responsible for the treatment, services or supplies provided by Network or Out-of-Network providers.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout the SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Definitions

Addendum - any attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Air Ambulance - medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in 42 CFR 414.605.

Allowed Amount - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator or determined as required by law as stated below.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Network Benefits, for Covered Health Care Services provided by a Network provider, except for cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount the plan will pay for Allowed Amounts.
  - For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria as described***

below, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in this SPD.

Network Benefits

Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are the Claims Administrator's contracted fee(s) with that provider.
- When covered health Care Services are received from an out-of-Network provider as arranged by the Claims Administrator, Allowed Amounts are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits

Allowed Amounts are based on either of the following:

When Covered Health Care Services are received from an Out-of-Network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by applicable state *All Payer Model Agreement*.
  - The reimbursement rate as determined by applicable state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by applicable state *All Payer Model Agreement*.
  - The reimbursement rate as determined by applicable state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by applicable state *All Payer Model Agreement*.
  - The reimbursement rate as determined by applicable state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined, based on either of the following:

- Negotiated rates agreed to by the Out-of-Network provider and either the Claim's Administrator or one of their vendors, affiliates or subcontractors.

- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS) for Medicare* for the same or similar service within the geographic market with the exception of the following.
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
    - 70% of *CMS* for the same or similar physical therapy services from a freestanding provider.
  - When a rate is not published by *CMS* for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, the Claims Administrator will use a comparable scale(s). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*.
    - For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale prices for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

The Claims Administrator updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amounts described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Health Service Act*.

Alternate Facility - 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 Health Care Services; or

- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Ancillary Charge - a charge, in addition to the Deductible, Copayment and/or Coinsurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product.
- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - The total Allowed Amount or the Recognized Amount when applicable you must pay for Covered Health Care Services per Calendar year before the Plan will begin paying Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The Schedule of Benefits will tell you if the plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition, marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Your right to payment for Covered Health Care Services that are available under the Plan.

Brand-name - a Prescription Drug Product:

- which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- that the Claims Administrator identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Calendar Year - January 1 through December 31.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Chiropractic Treatment (adjustments) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Claim Determination Period - a period of time during which you are covered by the plan.

Claims Administrator - United Healthcare Services, Inc. and its affiliates or subcontractors, who provide certain claim administration services for the Plan

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Allowed Amounts or the Recognized Amount when applicable, that you are required to pay for Covered Health Care Services.

Company - Westmoor Country Club

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

NOTE: For Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment; or
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating of a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this SPD under Section 5: *Additional Coverage Details* and in the Schedule of Benefits.
- Not excluded in this SPD under Section 6: *Exclusions*: What The Plan Will Not Cover.

Covered Person - The Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" in this SPD to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for more independent existence.

Definitive Drug Test - tests to identify specific medications, illicit substances and metabolites and is qualitative and quantitative to identify possible use of a drug.

Dependent - the Participant's legal Spouse or a child of the Participant or the Participant's Spouse. All references to the spouse of a Participant shall include a Domestic Partner, except for the purposes of coordinating Benefits with Medicare. The term child includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Claims Administrator is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under age 26;
- A child is no longer eligible as a Dependent when the child reaches age 26 except as provided in Section 3: *When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

The Participant must reimburse the Plan for any Benefits paid for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrators' behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Facility - a facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on behalf of the Plan to provide Covered Health Care Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or the Claims Administrator's pharmacy benefits manager to provide specific prescription drug products. The fact that a pharmacy is a member pharmacy does not mean that it is a Designated Pharmacy.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by accessing www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Domestic Partner - a person of the same or opposite sex with whom the Participant has a Domestic Partnership.

Domestic Partnership - A relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years of age.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally able to consent to contract.
- They must be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:

  They have a single dedicated relationship of at least 6 months duration.

  They have joint ownership of a residence.

  They have at least two of the following:
  - A joint ownership of an automobile.
  - A joint checking, bank or investment account.
  - A joint credit account.
  - A lease for a residence identifying both partners as tenants.
  - A will and/or life insurance policies which designate the other as primary beneficiary.

Durable Medical Equipment (DME)- medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.

- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an Employee of Westmoor Country Club or other person connected to Westmoor Country Club who meets the eligibility requirements shown in both the Plan Sponsor's application and the Plan. An Eligible Person must live within the United States.

Emergency - a medical condition that manifests itself by sudden symptoms of sufficient severity, (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department, to evaluate such Emergency; and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient, regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)*.
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
    a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical

transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by applicable state law.

e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Employee - a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Who is Eligible for Coverage?* in Section 2: *When Coverage Begins*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer -Westmoor Country Club

Enrolled Dependent - a Dependent who is covered under the Plan.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational); or
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial described in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 5: *Additional Coverage Details*.
- The Claims Administrator may, as it determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  1. You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 5: *Additional Coverage Details*; and
  2. You have a Sickness or condition that is likely to cause death with one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Emergency Department – an outpatient emergency department that is both licensed and physically separate and distinct from a Hospital and providers Emergency Health Care Services as permitted by law. A Freestanding Emergency Department is not an off-site Hospital-based Facility or satellite emergency department of a Hospital.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide heal decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Generic - a Prescription Drug Product:

- that is Chemically Equivalent to a Brand-name drug; or
- that the Claims Administrator identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Hearing Aid - an electronic amplifying device designed to bring sound more effectively into the ear. A Hearing Aid consists of microphone, amplifier and receiver.

Hearing Impairment - a reduction in the ability to perceive sound which may range from slight to complete deafness.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient Health Care Services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

Initial Enrollment Period - the first period of time at new business when Eligible Persons may enroll themselves and their Dependents under the Plan. The initial enrollment period ends once the installation process is complete and a policy number is generated for the group

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy) as authorized by law.

- a long term acute rehabilitation center,
- a hospital, or
- a special unit of a Hospital designated as an inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is Applied Behavior Analysis (ABA).

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Plan at a time other than the following:

- during the Initial Enrollment Period;
- during an Open Enrollment Period;
- during a special enrollment period as described in Section 2: *When Coverage Begins*; or

- within 31 days of the date a new Eligible Person first becomes eligible.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion
- Reduce pain
- Increase function.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to the Claims Administrator's periodic review and modification.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medical Child Support Order - any judgment, decree, or order including approval of a settlement agreement which is made:

- under a state domestic relations law and requires child support or requires health and/or dental coverage for the child; or
- by a state agency under a state law for medical child support that is required under the federal Social Security Act.

The Medical Child Support Order must be issued by a court of competent jurisdiction, or issued through a state administrative process, and has the force and effect of law.

Medical Necessity or Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or their designee:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder substance related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's authority.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting their determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on UHCProvider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services – services for the diagnosis and treatment of those mental health or psychiatric diagnostic categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement, and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The Schedule of Benefits will tell you details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons;
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- been designated by the Claims Administrator as a Network Pharmacy.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by the Claims Administrator or the Claims Administrator's designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Open Enrollment Period - thirty days prior to the renewal date of the Plan during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. Refer to Section 4: *Schedule of Benefits* for details about how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you may pay every Calendar Year. The Schedule of Benefits will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based program and provides services for at least 20 hours per week.

Participant - An Eligible Person (who is not a Dependent) who is properly enrolled under the Plan and is a full-time participant of the Plan Sponsor who meets the eligibility requirements specified in the Plan, as described under *Who is Eligible for Coverage?* in Section 2: *When Coverage Begins*. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA) approved prescription medication or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the Westmoor Country Club Medical Plan

Plan Administrator - Westmoor Country Club or its designee.

Plan Sponsor -Westmoor Country Club.

Predominant Reimbursement Rate - the charges incurred for a Prescription Drug Product not dispensed at a member pharmacy that will be considered covered expenses under the Plan. The Predominant Reimbursement Rate for a particular Prescription Drug Product includes the dispensing fee and sales tax. The Predominant Reimbursement Rate will be set at the Prescription Drug Product cost that the Claims Administrator's pharmaceutical benefits manager and most member pharmacies have agreed to for that Prescription Drug Product.

Prescription Drug Cost - the rate the Claims Administrator has agreed to pay the Claims Administrator's Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Prescription Drug List - a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Claims Administrator's periodic review and modification (generally twice a year, but no more than six times per Calendar Year). You may determine to which tier a particular Prescription Drug Product has been assigned through www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

Prescription Drug List Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers);
- Insulin;
- Certain immunizations administered in a Network Pharmacy.
- Certain Injectable medications administered in a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Presumptive Drug Tests - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- 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.

- 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.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication by calling Customer Care at the telephone number on your ID card.

Primary Care Physician - A Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Primary Plan - the plan which determines its benefits before those of the other Plan and without considering the other Plan's benefits.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Qualified - the Medical Child Support Order:

- creates or recognizes the child's right to receive health and/or dental coverage;
- includes the required name and last known mailing address of the child and a reasonable description of the coverage to be provided;
- includes the time period to which the Medical Child Support Order applies; and
- does not require a type of coverage not otherwise provided by the plan, except as necessary under applicable law.

Recognized Amount - the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers. The amount is based on either:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,

2) Applicable State law, or

3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Residential Treatment - treatment in a facility established and operated as required by law which provides Mental Health Care Services or Substance Related and Addictive Disorder Services. It must meet all of the following requirements:

- Provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and full- time participation.
- Provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Secondary Plan - the plan which determines its benefits after those of the other Plan. The benefits of the Secondary Plan may be reduced because of the other Plan's benefits.

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Plan.

Shared Savings Program - a program in which the Claims Administrator may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Coinsurance and any applicable deductible would still apply to the reduced charge. Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by the Claims Administrator. This means, when contractually permitted, the plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by the Claims Administrator. If this happens,

you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by the Claims Administrator.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the list of Preventive Medications. You may access a complete list of Specialty Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Related and Addictive Disorder Services - Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Terminally ill - A prognosis, given by a Physician, that a Covered Person has six months or less to live.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the American Society of Addiction Medicine (ASAM) Criteria and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain Health Care Services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

NOTE:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Health Care Reform Notice

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

ADDENDUM - Real Appeal

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, please access allsavers.realappeal.com or contact the number shown on your ID card.

Federal Women's Health and Cancer Rights Act of 1998

The Federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- Reconstruction of a surgically removed breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications from all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible and coinsurance provisions. They are also subject to medical insurance limitations and exclusions.

Questions? Call the member phone number on your health plan ID card.