DIGNITY HEALTH NATIONAL PPO

Medical Plan Document
7670-00-411829

2017

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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DIGNITY HEALTH NATIONAL PPO

MEDICAL PLAN DOCUMENT

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the DIGNITY HEALTH Welfare Benefit Plan (the "Plan"), which is commonly known as Flex*Ability*. You are a valued Employee of DIGNITY HEALTH, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs.

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

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. As a self-insured welfare plan and one that is covered by the Employee Retirement Income Security Act of 1974 (“ERISA”), the Plan constitutes an “employee welfare benefit plan” within the meaning of Section 3(1) of ERISA.

The Plan complies with applicable Federal civil rights and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Detailed information regarding the Plan’s Non-Discrimination Policy and the Dignity Health Discrimination Grievance Procedure may be found in the 2017 Dignity Health Summary Plan Description (SPD) which is located on the Dignity Health Total Rewards Portal at http://dignityhealthmember.org/totalrewards.

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

This document describes the DIGNITY HEALTH NATIONAL PPO provisions and benefits. Covered Employees and eligible Dependents are responsible for reading this document and related materials completely and complying with all the rules and provisions of the Plan.

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

The Plan Document will govern if there are discrepancies between its provisions and the information in this Medical Plan Document. The formal plan documents, texts and insurance contracts which govern the operations of various plans and copies of official documents and reports are on file for review by eligible participants and beneficiaries at the following location, by appointment.

DIGNITY HEALTH
185 BERRY ST STE 300
SAN FRANCISCO CA 94107

This document becomes effective on January 1, 2016.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003 – Dignity Health National PPO Plan

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

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

Important: Prior authorization may be required before benefits will be considered for payment. You are responsible for obtaining prior authorization for certain out-of-network services. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this Medical Plan Document for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

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

	UnitedHealthcare Choice Plus Network	**Out-Of-Network**
Annual Deductible Per Calendar Year:		
• Per Person	$250	$500
• Per Family	$750	$1,500
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	90%	50%
Annual Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum:		
• Per Person	$4,500	$10,000
• Per Family	$9,000	$30,000
Acupuncture Treatment: 20 Visit Limit Combined With Chiropractic And Manipulations		
• Co-pay Per Visit	$45	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	90%	90%
Breast Pumps:		No Benefit
• Paid By Plan	100% (Deductible Waived)	

	UnitedHealthcare Choice Plus Network	Out-Of-Network
Chiropractic Services / Manipulations: • Co-pay Per Visit • Maximum Visits Per Calendar Year Including Acupuncture • Paid By Plan	 $45 20 Visits 100% (Deductible Waived)	No Benefit
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: **For Women:** • Paid By Plan After Deductible	 100% (Deductible Waived)	 50%
Durable Medical Equipment: • Paid By Plan After Deductible	 90%	 50
Emergency Services / Treatment: **Urgent Care:** • Co-pay Per Visit • Paid By Plan After Deductible **True Emergency Room / Emergency Physicians:** • Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan	 $50 100% (Deductible Waived) $250 100% (Deductible Waived)	 Not Applicable 50% $250 100% (Deductible Waived)
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Sub-Acute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 120 Days 90%	 50%
Hearing Services: • Paid By Plan After Deductible **Hearing Aids:** • Maximum Benefit Every Five Years • Maximum Benefit Per Hearing Aid • Paid By Plan After Deductible	 90% 1 Hearing Aid Per Ear $4,000 90%	 50% 50%
Home Health Care Benefits: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	 $30 120 Visits 100% (Deductible Waived)	 Not Applicable 50%
Hospice Care Benefits: • Paid By Plan After Deductible	 90%	 50%

	UnitedHealthcare Choice Plus Network	Out-Of-Network
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	90%	50%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	90%	50%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	90%	50%
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	90%	50%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	90%	50%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	90%	50%
Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	90%	50%
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
Inpatient Services / Physician Charges:		
• Paid By Plan After Deductible	90%	50%
Residential Treatment:		
• Paid By Plan After Deductible	90%	50%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan After Deductible	90%	50%
Office Visit:		
• Co-pay Per Visit	$30	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	UnitedHealthcare Choice Plus Network	Out-Of-Network
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible And / Or Co-pay Will Be Waived For Preventive / Routine Well Newborn Charges, Initial Stay (Days 0-5).***	90%	50%
Physician Office Services: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan After Deductible	$30 $45 100% (Deductible Waived)	Not Applicable Not Applicable 50%
Allergy Injections: • Paid By Plan After Deductible	90%	50%
Allergy Serum: • Paid By Plan After Deductible	90%	50%
In-Office Chemotherapy: • Paid By Plan After Deductible	90%	50%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan **Immunizations:** • Paid By Plan **Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:** • Paid By Plan **Preventive / Routine Mammograms And Breast Exams:** From Age 35 To Age 40 • Maximum Exams Per Calendar Year From Age 40 • Maximum Exams • Paid By Plan **Preventive / Routine Pelvic Exams And Pap Tests:** • Maximum Exams Per Calendar Year • Paid By Plan	 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 1 Baseline Exam 1 Exam 100% (Deductible Waived) 1 Exam 100% (Deductible Waived)	No Benefit

	UnitedHealthcare Choice Plus Network	Out-Of-Network
Preventive / Routine PSA Test And Prostate Exams: From Age 40 • Maximum Exams Per Calendar Year • Paid By Plan	 1 Exam 100% (Deductible Waived)	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan	 100% (Deductible Waived)	
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: From Age 50 • Paid By Plan	 100% (Deductible Waived)	
Note: First Colonoscopy Submitted Per Calendar Year Is Paid As Routine Regardless Of Diagnosis. Subsequent Colonoscopies Will Be Paid As Billed.		
Preventive / Routine Hearing Exams: • Paid By Plan	 100% (Deductible Waived)	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet And Nutrition: • Paid By Plan	 100% (Deductible Waived)	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride: • Paid By Plan	 100% (Deductible Waived)	
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Treatment For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan After Deductible	 100% (Deductible Waived)	
***These Services May Also Apply To Men.**		

	UnitedHealthcare Choice Plus Network	Out-Of-Network
Private Duty Nursing:		
• Maximum Visits Per Calendar Year	70 Visits	
• Paid By Plan After Deductible	90%	50%
Sterilizations: **For Women:**		No Benefit
• Paid By Plan	100% (Deductible Waived)	
Temporomandibular Joint Disorder Benefits:		
• Paid By Plan After Deductible	90%	50%
Therapy Services:		
• Co-pay Per Visit	$30	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Note: Medical Necessity Will Be Reviewed After 25 Visits.		
Transplant Services At A Designated Transplant Facility: **Transplant Services:**		No Benefit
• Paid By Plan After Deductible	90%	
Travel And Housing:		
• Maximum Benefit Per Transplant	$10,000	
• Paid By Plan	100% (Deductible Waived)	
Note: Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.		
All Other Covered Expenses:		
• Paid By Plan After Deductible	90%	50%

PRESCRIPTION SCHEDULE OF BENEFITS OPTUMRX Benefit Plan(s) 003 – Dignity Health National PPO Plan	
Prescription And OTC Smoking Deterrents: • Maximum Benefit Per Calendar Year	 $500
Infertility Products: • Maximum Benefit Per Calendar Year	 $1,000
Annual Out-of-Pocket Maximum Per Calendar Year: • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Nothing For Covered Prescription Medication.	 $2,100 $4,200
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) Non-Preferred Brand-Name Drugs (Tier 3)	 For Up To A 31-Day Supply: $14 $50 $90
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Drug Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) Non-Preferred Brand-Name Drugs (Tier 3)	 For Up To A 90-Day Supply: $20 $70 $140
Specialty Drugs • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Brand-Name Drugs (Tier 2) ***Note: Specialty Drugs Must Be Purchased Through OptumRx Specialty Pharmacy.***	 For Up To A 30-Day Supply: 25% With A Minimum Of $25 And A Maximum Of $50 25% With A Minimum Of $25 And A Maximum Of $50
By Non-Participating Pharmacy	No Benefit

Note: The Co-pay may not apply to preventive Prescription and over-the-counter products and contraceptives.

ANCILLARY CHARGES

Your out-of-pocket cost for a Prescription medication can often vary depending on whether You receive a generic or a brand-name medication. We are providing this information about our ancillary charges to help You understand Your options for choosing between a generic and a brand-name medication and how Your choice affects how much You will contribute toward the price of Your medication.

- **If You choose a lower-cost generic medication** – You will pay only Your cost share (e.g., Co-pay) with no additional cost.

- **If You choose a preferred brand-name medication, where there is no generic equivalent available** – You will pay Your cost share (e.g., Co-pay).
- **If You choose a higher-cost brand-name medication, where there is a generic equivalent available** – You will pay Your cost share, plus the difference in price between the brand-name and the generic drug.

In the example below, the brand-name medication cost $250 and the lower-cost generic is $50. The ancillary charge for a member who purchases the brand medication where there is a generic equivalent available would be $200.

Type of Prescription Medication	Point of Purchase/ Supply	Cost of Prescription Medication	Co-pay	Ancillary Charge	Maximum Amount Member Pays Out-of-Pocket
Brand Medication	Retail Pharmacy 1-Month Supply	$250	$50	$200	$250
Generic Equivalent Medication	Retail Pharmacy 1-Month Supply	$50	$14	$0	$14

The ancillary charge is the difference in price between the brand-name medication and the lower-cost generic equivalent medication. It is a cost that You pay in addition to Your share. In this example, Your cost share is $50. When added to the ancillary charge, Your maximum cost for the brand-name medication is $250 ($200 + $50). You will never pay more than the total cost of the Prescription medication. You have the option to pay only $14, if You choose the lower-cost generic medication.

The ancillary charge only applies if You choose a brand name medication, where there is a generic equivalent available. However, once You reach Your plan's maximum out-of-pocket amount, it is no longer applicable.

Following are several commonly asked questions about the ancillary charges and generic versus brand medications. The responses are meant to help You, as a health care consumer, understand Your Prescription options, make the right choices and avoid paying too much.

Q. If I have tried a generic medication with poor results, and my doctor put me back on the higher-cost brand medication, must I still pay the ancillary charge?

A. Yes. If You tried the generic medication and do not wish to continue taking it for any reason, You can request the brand. However, You will be responsible for paying the ancillary charge, in addition to Your cost share.

Q. If my doctor has indicated "dispense as written" with a Prescription for a brand medication, am I required to pay the ancillary charge?

A. Yes. If You or Your doctor has requested that Your Prescription for a brand medication be "dispensed as written" and a lower-cost generic medication is available, You will be responsible for the ancillary charge, in addition to your cost share. If You do not want to pay the ancillary charge, ask Your doctor if a lower-cost generic equivalent medication is right for You.

Q. What is the difference between brand-name and generic medications?

A. Generic and brand name drugs contain the same active ingredient. While You may be familiar with a brand-name medication because of advertising, often there are several Prescription drugs that contain the same active ingredient and treat the same condition. Some drugs may cost much more than others, even though they share the same active ingredient. Both brand and generic Prescription medications are approved by the U.S. Food and Drug Administration (FDA).

Q. Why do brand and generic medications differ so in price?

A. When a new brand-name medication becomes available, it may be the only drug to treat a certain condition and, therefore, command a high price. The developer's new drug research and start-up costs can contribute to a high market price, and advertising can drive up the price of a medication. Over time, other medications are developed to treat a condition. This creates competition, which can lead to lower prices. Also, once a brand medication's patent protection ends, generic versions can be made by multiple companies. This can also lead to less expensive options. Generic medications are usually Your lowest-cost option, but not always.

Q. How can I tell if a drug is brand or generic?

A. The OptumRx Prescription Drug List (PDL), which can be found at umr.com > prescriptions, organizes commonly prescribed brand and generic drugs according to the condition they're meant to treat. The cost level (tier) is included. We encourage You to bring the PDL with You to Your doctor's appointment so You and Your doctor can discuss the most cost-effective Prescription medication options for You.

Q. How can I find out how much a drug costs -- and whether the ancillary charge was applied correctly if I received a brand name drug rather than a generic?

A. To check medication prices, members can log into umr.com > prescriptions, by clicking the Online Pharmacy link under Your Pharmacy Coverage in the Tools & Resources section. Use the online medication price check feature of the OptumRx website or call Customer Care for assistance. You can also price check brand versus generic medications at Your retail Pharmacy by giving the pharmacist the names of the brand and generic medications recommended by your doctor. Keep in mind that drug classifications and pricing are continually changing so You should check these sources each time you fill a Prescription for the most current information.

Q. Do all brand-name drugs have generic equivalents?

A. No. All brand-name drugs do not necessarily come in generic form. Generic versions cannot be produced until after the patent on the brand drug expires and they are tested and approved by the FDA. A brand-name Prescription medication without a lower-cost generic alternative is not subject to the ancillary charge.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 003 – Dignity Health National PPO Plan

CO-PAYS

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

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits.

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

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

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

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or 140 percent of the published rates allowed by Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network and out-of-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the medical out-of-pocket maximum of this Plan. Pharmacy out-of-pocket maximum is referenced in the Pharmacy Schedule of Benefits.

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

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Plan Participation amounts for Prescription products.
- Expenses Incurred as a result of failure to comply with prior authorization requirements for Hospital confinement.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

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

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. Specific information, shown below, can be found in documents located on the Dignity Health Total Rewards Portal at http://dignityhealthmember.org/totalrewards.

- Who is eligible for the plans?
- Who are Your eligible Dependents?
- Selecting Your family coverage categories.
- Enrolling in *FlexAbility.*
- Qualified life events affecting Your coverage
- If You do not enroll, and
- Special enrollment rules.

If You have questions about Your Dignity Health benefits, call the Dignity Health HR Service Center at 1.855.475.4747 and press 1 for benefits.

CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Your Employer, as sponsor of this Plan, is required to comply with the health care continuation coverage rules of ERISA and the Internal Revenue Code. Please refer to the Dignity Health Summary Plan Description (SPD) located on the Dignity Health Total Rewards Portal at http://dignityhealthmember.org/totalrewards for detailed information on all aspects related to continuation coverage.

Information regarding the following topics is also covered under the Continuation Coverage section in the Dignity Health Summary Plan Description (SPD).

- Continuation of coverage.
- Your right to convert coverage.
- Family and Medical Leave Act (FMLA) coverage.
- USERRA.

For questions about Continuation Coverage, call the Dignity Health HR Service Center at 1.855.475.4747 and press 1 for benefits.

PROVIDER NETWORK

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

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

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

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

  Tier One – UnitedHealthcare Choice Plus Network

- If a provider belongs to the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  First Health/MP/TC3
  First Health Shared Savings

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

Reimbursement for Covered Expenses received from Non-Network Physicians or health care facilities are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility;
- If fees have not been negotiated:
  - 140 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market; or
  - A gap methodology may be utilized when CMS does not have rates published for certain procedural codes. In such instances, a rate methodology derived by OptumInsight will be utilized.
  - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price 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; or

- 50 percent of the provider's billed charges when unable to obtain a rate published by CMS and/or gap methodology does not apply.

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

The program for Transplant Services at Designated Transplant Facilities is:

- OptumHealth or a Dignity Health-owned facility

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Covered Inpatient Admissions as a result from an Emergency Room Visit will be payable at the Tier 1 level of benefits. Covered Persons should contact UMR to review these situations on a case-by-case basis.
- Covered Services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist when services are out of the members' control and performed at a Tier 1 or Tier 2 facility will waive Usual & Customary cuts for Non-Network providers. The Non-Network provider would be reimbursed at the payment level of the Network facility.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, can access, at no cost, a list of the participating Network providers for this Plan at www.UMR.com. A hard-copy directory can also be made available by calling the number on the back of the ID card. The Employee should share this website or document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should call the number on the back of the ID card.

COVERED MEDICAL BENEFITS

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

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

Important: Prior authorization may be required before benefits will be considered for payment. In general, network providers are responsible for notifying the Third Party Administrator (UMR) before they provide these services to You. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this Medical Plan Document for a description of these services and prior authorization procedures.

When You choose to receive services from Out-of-Network providers, we urge You to confirm with us that the service You plan to receive is a covered medical benefit, even if not indicated in the Services Requiring Prior Authorization section. That's because in some instances, certain procedures may not meet the definition of a covered medical benefit and therefore are excluded. In other instances, the same procedure may meet the definition of covered medical benefit. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions. To notify UMR, have Your provider call the telephone number on Your ID card.

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

2. **Acupuncture Treatment.**

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

4. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically-appropriate Hospital.

5. **Anesthetics and Their Administration.**

6. **Autism Spectrum Disorders (ASD) Treatment**, when Medical Necessity is met.

   If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 25 hours per week for 3-6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity. Applied Behavioral expenses Incurred by a Covered Person up to age 7 for services for the diagnosis and treatment of autism. Benefits are payable in the same way as those for any other disease.

(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy.

Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).

Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).

Does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

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

8. **Breast Reductions** if Medically Necessary.

9. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

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

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

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

    Covered services include:

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

12. **Cataract or Aphakia Surgery** as well as surgically implanted protective lenses following such a procedure.

13. **Chiropractic Services/ Manipulations:** Services, which are rendered by a licensed chiropractor or Physician for treatment of musculoskeletal conditions when Medically Necessary to include but not limited to the detection or correction, by manual or mechanical means of structural imbalance, distortion or subluxation, where such care is for purposes of removing nerve interference and its effects. Also refer to Maintenance Therapy under the General Exclusions section of this Medical Plan Document.

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

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

16. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

17. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that a Covered Person self-administers will be processed under the Prescription Benefits section of this document (oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this Medical Plan Document.

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

19. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 24 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for X-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

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

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

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

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

- ➢ because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
- This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

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

24. **Emergency Services Provided in a Foreign Country**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office.

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

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

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

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

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

28. **Gender Dysphoria:**

    Benefits for the treatment of Gender Dysphoria, limited to the following services:

    - Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.
    - Cross-sex hormone therapy:
      - ➢ Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) as described in the Mental Health Benefits section of this SPD.
      - ➢ Cross-sex hormone therapy dispensed from a pharmacy as described in the Prescription Drug Benefits section of this SPD.
    - Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
    - Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
    - Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:

    A Covered Person seeking Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery will be required to provide certain documentation. For details regarding surgeries for the treatment of Gender Dysphoria and associated criteria, contact UMR at 1.877.217.7800.

    - Treatment plans must be based on identifiable external sources, including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

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

    Genetic Testing MUST meet the following requirements:

    The test is not considered experimental or investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

    And must meet at least one of the following:

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

    Generally, genetic testing is not covered for:

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

30. **Hearing Services** include:

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

31. **Home Health Care Services:** (Refer to Home Health Care section of this Medical Plan Document).

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

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.

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

33. **Hospital Services (Includes Inpatient Services, Surgical Centers And Inpatient Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.

- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma and plasma expanders, when not available without charge.

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

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

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

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

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

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

38. **Mental Health Treatment** (Refer to Mental Health section of this Medical Plan Document).

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

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

    Well baby expenses for the covered newborn will be processed under the mother's benefits. After infant is delivered, and is a separate individual, items and services furnished to the infant are not covered on the basis of the mother's eligibility. Employee must enroll the newborn within 31 days of birth through the Dignity Health Total Rewards Portal in order for the newborn to be covered. (Refer to the Eligibility and Enrollment section of this guide.) If the covered newborn needs to stay in the Hospital longer than the mother following the delivery, those charges will be processed under the newborn's benefits subject to the Deductible and other Plan provisions, including HIPAA Special Enrollment.

41. **Nutritional Counseling** if Medically Necessary.

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

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

44. **Oral Surgery** includes:

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

45. **Orthognathic, Prognathic And Maxillofacial Surgery** when Medically Necessary.

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

    Custom-molded foot orthotics are only allowable for Covered Persons with a diagnosis of diabetes.

47. **Oxygen and Its Administration.**

48. **Pharmacological Medical Case Management** (Medication management and lab charges).

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

50. **Physician Services** for covered benefits.

51. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

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

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

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

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

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus; and
  - Screening and counseling for interpersonal and domestic violence.

  Please visit the following links for additional information:

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

54. **Private Duty Nursing Services** when Outpatient care is required and Medically Necessary 24 hours a day. This does not include Inpatient private duty nursing services.

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

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

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

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

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

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

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

Routine patient care costs for Qualifying Clinical Trials may include:

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

Routine costs for clinical trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - *National Institutes of Health (NIH),* including the *National Cancer Institute (NCI);*
    - *Centers for Disease Control and Prevention (CDC);*
    - *Agency for Healthcare Research and Quality (AHRQ);*
    - *Centers for Medicare and Medicaid Services (CMS);*
    - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veteran's Administration (VA);*
    - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
    - The *Department of Veterans Affairs*, the *Department of Defense,* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
        - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health; and*
        - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

57. **Radiation Therapy and Chemotherapy.**

58. **Radiology and Interpretation Charges.**

59. **Reconstructive Surgery or Cosmetic Surgery and Supplies:**

- Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Charges made by a Physician, Hospital, or surgery center for reconstructive services and supplies, including:
  - Surgery needed to improve a significant functional impairment of a body part.
  - Surgery to correct the result of an accidental Injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original Injury. For a covered Child, the time period for coverage may be extended through age 25.
  - Surgery to correct the result of an Injury that occurred during a covered surgical procedure, provided that the reconstructive surgery occurs no more than 24 months after the original injury. Note: Injuries that occur as a result of a medical (i.e., non surgical) treatment are not considered accidental Injuries, even if unplanned or unexpected;
  - Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury) when:
    - the defect results in severe facial disfigurement; or
    - the defect results in significant functional impairment and the surgery is needed to improve function.

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

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

62. **Sleep Disorders** if Medically Necessary.

63. **Sleep Studies.**

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

65. **Sterilizations.** Vasectomy is covered only if Medically Necessary.

66. **Substance Use Disorder Services.** Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this Medical Plan Document.)

67. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

68. **Telemedicine – Telephone or Internet Consultations:** Consultations made by a Covered Person's treating Physician to another Physician. Consultations made by a Covered Person to a Physician.

69. **Temporomandibular Joint Disorder (TMJ) Services** includes:

- Diagnostic services.
- Surgical treatment.

This does not cover orthodontic services.

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

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
- **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

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

72. **Transplant Services** (Refer to Transplant section of this Medical Plan Document).

73. **Urgent Care Facility** as shown in the Schedule of Benefits of this Medical Plan Document.

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

HOME HEALTH CARE BENEFITS

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

Prior authorization may be required before receiving services. Please refer to the Care Management section of this Medical Plan Document for more details. Covered services may include:

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

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

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

Refer to the Care Management section of this Medical Plan Document for prior authorization requirements

DEFINITIONS

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

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

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

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

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

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

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

COVERED EXPENSES

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

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

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

Benefits are payable for the following transplants:

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

SECOND OPINION

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

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

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

Covered travel and housing expenses include the following:

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

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

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

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

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

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

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

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

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

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

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

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

PRESCRIPTION DRUG BENEFITS

What this section includes:

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

Prescription Drug Benefit Highlights

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

Network Pharmacies

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

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

- **OptumRx National Pharmacy Network:** The OptumRx National Network lets you fill Prescriptions at thousands of retail pharmacies nationwide. The network has more than 65,000 participating pharmacies across the United States. Major drugstores, mass retailers and supermarkets make up a large part of the network. You have two ways to quickly and easily find a nearby pharmacy:
  - www.UMR.com, and navigate to the myPharmacyCenter section;
  - Contact Customer service by calling the toll-free number on the back of Your health plan ID card.

Benefit Levels

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

The Plan pays benefits at different levels for tier 1, tier 2, and, if applicable, tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan (exclusions and limitations apply) are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug may change periodically, as frequently as monthly, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, for the most current information, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877.559.2955.

Each tier is assigned a Co-pay or Participation, which is the amount You pay when You visit the pharmacy or order Your medications through mail order. Your Co-pay or Participation will also depend on whether or not You visit the pharmacy or use the mail order service; see the Prescription Schedule of Benefits for further details. Tier 1 is Your lowest Co-pay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

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

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

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

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

Retail

The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by visiting www.UMR.com, and navigating to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955.

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

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

Mail Order

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

To use the mail order service, all You need to do is complete a patient profile and enclose Your Prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after Your order is received. If You need a patient profile form, or if You have any questions, You can reach OptumRx at 1.877.559.2955.

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

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

Note: To maximize Your benefit, ask Your Physician to write Your Prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-pay or Participation amount for any Prescription order or refill if You use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure Your Physician writes Your mail order or refill for a 90-day supply, not a 31-day supply with three refills.

Designated Pharmacy for Specialty Prescriptions

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

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

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

Get the most out of your Pharmacy Benefit. By guiding You to lowest cost options, your Pharmacy Benefit offers flexibility and choice. This is why we recommend considering tier 1 Prescription Drugs, if You and Your Physician decide they are appropriate. OptumRx evaluates medications based on their total value, including how they work and how much they cost. When two or more medications work the same way, other factors, including cost, may play a role in tier placement, meaning the cost level You pay for a medication. Many times, when a higher-cost medication is in a higher tier (tier 2 or tier 3), we are able to provide more medication choices in a lower tier (tier 1), meaning a lower cost for You.

Assigning Prescription Drugs to the PDL

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

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

Economic factors may include:

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

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

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

Prescription Drug, Prescription Drug List (PDL), and P&T Committee are defined at the end of this section.

Prescription Drug List (PDL)

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

Prior Authorization Requirements

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

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

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

Network Pharmacy Prior Authorization

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

Prior Authorization

To determine if a Prescription Drug requires prior authorization, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955. The Prescription Drugs requiring prior authorization are subject to periodic review and modification.

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

We may also require prior authorization for certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation, or activation requirements associated with such programs through the Internet at www.UMR.com, and navigating to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955.

Limitation on Selection of Pharmacies

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

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per Prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955. Whether or not a Prescription Drug has a supply limit is subject to OptumRx's periodic review and modification.

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

If a Brand-name Drug Becomes Available as a Generic

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

Special Programs

DIGNITY HEALTH and OptumRx may have certain programs in which You may receive an enhanced or reduced benefit based on Your actions such as adherence to or compliance with medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.UMR.com, and navigating to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955.

Rebates and Other Discounts

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

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

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

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

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

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

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

- **Tobacco Cessation.** Some tobacco cessation products may be covered, and may be subject to age restrictions.

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

Covered Expenses apply only to certain Prescription Drugs and supplies. You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955, for information on which specific Prescription Drugs and supplies are covered.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover

In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 1.877.559.2955 for information on which Prescription Drugs are excluded.

Excluded medications are:

- For any condition, Injury, sickness or Mental Health Disorder arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which benefits are provided in the medical (not in the Prescription Drug Benefits) portion of the Plan;
- Available over-the-counter that do not require a Prescription order or refill by federal or state law before being dispensed, unless the Plan has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision;
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription order or refill. Compounded drugs that are available as a similar, commercially available Prescription Drug;
- Dispensed outside of the United States, except in an Emergency;
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- The amount dispensed (days' supply or quantity limit) that exceeds the supply limit;
- The amount dispensed (days' supply or quantity limit) that is less than the minimum supply limit;
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
- Prescribed, dispensed, or intended for use during an Inpatient stay;
- Prescription Drugs, including New Prescription Drug Products or new dosage forms, that OptumRx and DIGNITY HEALTH determines do not meet the definition of a Covered Expense;
- Used for conditions and/or at dosages determined to be Experimental, Investigational, or Unproven, unless OptumRx and DIGNITY HEALTH have agreed to cover an Experimental, Investigational, or Unproven treatment, as defined in the Glossary of Terms;
- Vitamins, except for the following, which require a Prescription:
  - Prenatal vitamins;
  - Vitamins with fluoride; and
  - Single-entity vitamins.
- Allergy sera and extracts;
- Biological sera, blood, blood plasma, blood products or substitutes or any other blood products;
- Drugs used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Drugs used for the treatment of obesity;
- Food items: Any food item, excluding infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition;
- Rogaine (or similar products);
- Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids;
- Test agents except diabetic test agents.

DEFINITIONS

Brand-name means a Prescription Drug that is either:

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

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

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

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

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by OptumRx as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.
- You should know that all products identified as “Generic" by the manufacturer, the pharmacy, or Your Physician may not be classified as Generic by OptumRx.

Network Pharmacy means a retail or mail order pharmacy that has:

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

New Prescription Drug Product means a Prescription Drug product or new dosage form of a previously approved Prescription Drug product, for the period of time starting on the date the Prescription Drug product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by OptumRx’s PDL Management Committee; or
- December 31st of the following calendar year.

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

PDL: see Prescription Drug List (PDL).

Pharmacy and Therapeutics (P&T) Committee means the committee that OptumRx designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

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

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

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

Prescription Drug List (PDL) means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.UMR.com, and navigating to the myPharmacyCenter section, or calling OptumRx at 877.559.2955.

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

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

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

MENTAL HEALTH BENEFITS

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

COVERED BENEFITS

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

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions or substance-related disorders. (Coverage does not include services provided in a community-based residential facility or group home.)

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

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

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

MENTAL HEALTH EXCLUSIONS

As further clarification to the General Exclusions section, benefits will NOT be provided for any of the following:

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

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this Medical Plan Document.

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

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

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

- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

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

COVERED BENEFITS

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

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions or substance-related disorders. (Coverage does not include services provided in a community-based residential facility or group home.)

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

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

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

SUBSTANCE USE DISORDER EXCLUSIONS

As further clarification to the General Exclusions section, benefits will NOT be provided for any of the following:

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

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

CARE MANAGEMENT

Utilization Management

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

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

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Care Management section of this Medical Plan Document. Refer to the Glossary of Terms section of this Medical Plan Document for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay. In general, network providers are responsible for notifying the Utilization Review Organization (UMR Care Management) before they provide services to You.

You must provide prior notification for certain services if You choose to receive services from out-of-network providers. Refer to the Services Requiring Prior Authorization for description of these services and prior authorization procedures. Failure to obtain prior authorization may result in a $250 penalty.

When You choose to receive services from out-of-network providers, we urge You to confirm with us that the service You plan to receive is a covered medical Benefit, even if not indicated in the Services Requiring Prior Authorization section. That's because in some instances, certain procedures may not meet the definition of a covered medical benefit and therefore are excluded. In other instances, the same procedure may meet the definition of covered medical benefit. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions. To notify UMR, call the telephone number on Your ID card.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment) or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Network providers must call the Utilization Management Organization (UMR) **before** providing services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces or orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.
- Prosthetics over $1,000.
- Qualifying Clinical Trials.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- MRI, MRA, CT, CTA, PET and nuclear cardiology scans.
- Chemotherapy.
- Radiation therapy.
- Dialysis.
- ABA therapy for treatment of Pervasive Developmental Disorders/autism. Limit ABA therapy up to age 7 for autism.
- Outpatient Orthopedic Implants.

Have Your provider call the Utilization Management Organization (UMR) **before** receiving services for the following:

- Out-of-network Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Out-of-network partial hospitalizations.
- Out-of-network organ and tissue transplants.
- Out-of-network Home Health Care.
- Out-of-network Durable Medical Equipment, including braces or orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.
- Out-of-network prosthetics over $1,000.
- Out-of-network Qualifying Clinical Trials.
- Out-of-network Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Out-of-network MRI, MRA, CT, CTA, PET and nuclear cardiology scans.
- Out-of-network rhemotherapy.
- Out-of-network radiation therapy.
- Out-of-network dialysis.

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

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $250 may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization.

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

The fact that a Covered Person provides Prior Authorization from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this Medical Plan Document.

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

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. Information is easily passed from utilization management to case management through our fully integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within 30 calendar days of the receipt of request unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Disease Management Program

The **Disease Management** Program identifies those individuals who have certain chronic diseases and would benefit from this program. Condition coaches work telephonically with Covered Persons to help them improve their chronic diseases and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, Chronic Obstructive Pulmonary Disease, diabetes, hypertension, and depression as a comorbidity linked to another chronic condition we manage). Built within our system is a predictive modeling tool, Aerial Analytics and Clinical Intelligence Rules, that takes up to two years' worth of medical and pharmacy claims data and then identifies those Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates are initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referral, NurseLine referrals, the employer, or the Covered Person's Physician.

In addition to the telephonic services, UMR disease management also provides HealtheNotes. These targeted mailings are sent to Covered Persons' homes and their health care providers via U.S. mail. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs. Opportunities or gaps in care are identified through medical and/or pharmacy data.

HealtheNotes provides useful, personalized information based on an individual Covered Person's health care utilization, including information on provider visits, Prescriptions, and health screenings.

HealtheNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing overall health care costs.

Maternity Management

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term-deliveries and decreases the cost of a long term hospital stay for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation. The standard incentive is a gift card. Each Covered Person who enrolls via the web receives a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling the toll-free number located on the back of Your medical plan ID card. They are then contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education and materials based on their needs. The nurses also help members understand their Plan's benefit information.

Case Management

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants, and trauma cases. UMR Care Management's nurse case managers identify, coordinate, and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated, diagnosis-based trigger list during the prior authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician, and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine/Nurse Chat

NurseLine service is a health information line that is available 24 hours per day, 7 days per week, that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

Nurse Chat is an online source of health and wellness information that is available 24 hours per day, 7 days per week. Covered Persons have one-on-one secure, real-time access to registered nurses through the Health Center on umr.com. These nurses provide information on a variety of health and wellness topics. Note: Triage is not part of the Nurse Chat experience. If a Covered Person needs triage assistance, Nurse Chat refers the Covered Person to NurseLine.

COORDINATION OF BENEFITS

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

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

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

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See the order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE

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

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

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

Note: If a Covered Person is eligible for Medicare as his or her Primary Plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether or not the Covered Person is enrolled in Medicare.

TRICARE

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

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

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL EXCLUSIONS

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

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

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

2. **Active Duty in the Armed Forces.** Any loss suffered while on full time duty in the armed forces of any country.

3. **Allergy.** Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.

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

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

6. **Aquatic Therapy.**

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

8. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

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

10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

11. **Bereavement Counseling.**

12. **Biofeedback Services.**

13. **Blood:** Blood donor expenses.

14. **Blood Pressure Cuffs / Monitors.**

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

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

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

18. **Contraceptive Products and Counseling**, unless covered under the Prescription Drug Program benefits, outlined in this Medical Plan Document.

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

20. **Counseling.** Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counseling, unless Medically Necessary.

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

22. **Criminal Activity:** Any Injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such Injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression).

23. **Custodial Care** as defined in the Glossary of Terms of this Medical Plan Document.

24. **Dental Services:** Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of Injuries and Illnesses of the teeth, gums, and other structures supporting the teeth, except for the prompt repair of Injury to the teeth and tissue supporting the teeth as a result of an Injury. This includes but is not limited to:

    - Services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
    - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace and reposition teeth; and
    - Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

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

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

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

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

29. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

30. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Benefits section of this Medical Plan Document.

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

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

33. **Foot care:** Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

    - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
    - Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an Illness or Injury.
    - Palliative Foot Care.
    - Non-custom-molder shoe inserts.

34. **Foreign Coverage for Medical Care Expenses which includes Preventive Care or elective treatment**, except for services that are Incurred in the event of an Emergency. Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or Physician services in a provider's office, as shown in the Schedule of Benefits.

35. **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, or trachea shave (removal or reduction of the Adam's Apple).
    - Voice modification surgery.
    - Voice lessons and voice therapy.

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

37. **Genetic Testing** unless covered elsewhere in this Medical Plan Document.

38. **Growth/Height:** Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.

39. **Hair Loss:** Care and treatment for hair loss, including wigs, hair transplants/implants or any drug that promises hair growth, whether or not prescribed by a Physician, unless covered elsewhere in this Medical Plan Document.

40. **Hearing Services:** Implantable hearing devices.

41. **Home Births** and associated costs.

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

43. **Home Uterine Activity Monitoring.**

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

45. **Infertility Treatment:**

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

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

46. **Lamaze Classes** or other child birth classes.

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

48. **Liposuction** regardless of purpose.

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

50. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this Medical Plan Document.

51. **Massage Therapy.**

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

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

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

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

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

57. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

58. **Nutrition Counseling** unless covered elsewhere in this Medical Plan Document.

59. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

60. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this Medical Plan Document.

61. **Panniculectomy / Abdominoplasty** unless determined by the Plan to be Medically Necessary.

62. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

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

64. **Preventive / Routine Care Services** unless covered elsewhere in this Medical Plan Document.

65. **Private Duty Nursing Services.** Charges for private duty nursing during Your stay in a Hospital or outpatient setting, unless covered elsewhere in this Medical Plan Document.

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

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

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

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

70. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

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

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

73. **Services of a resident Physician or intern rendered in that capacity.**

74. **Services Provided by a Close Relative.** See Glossary of Terms of this Medical Plan Document for definition of Close Relative.

75. **Sex Therapy.**

76. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this Medical Plan Document) in connection with treatment for male or female impotence.

77. **Spinal Disorder**, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine, including manipulation of the spine treatment, unless covered elsewhere in this Medical Plan Document.

78. **Standby Surgeon Charges.**

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

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

81. **Taxes:** Sales taxes, shipping and handling, unless covered elsewhere in this Medical Plan Document.

82. **Telemedicine - Telephone or Internet Consultations.**

83. **Temporomandibular Joint Disorder (TMJ) Services:** Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension). This does not cover orthodontic services.

84. **Therapies for the Treatment of Delays in Development.** Unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Down syndrome and cerebral palsy, as they are considered both developmental and/or chronic in nature.

85. **Tobacco Addiction:** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine unless covered elsewhere in this Medical Plan Document.

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

87. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

88. **Vision Care** unless covered elsewhere in this Medical Plan Document.

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

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

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

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

93. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, where required by state law, policy or contract, whether or not such policy or contract is actually in force.

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

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

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

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

Pre-Determination

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

TYPE OF CLAIMS AND DEFINITIONS

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

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

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

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

PERSONAL REPRESENTATIVE

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

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

PROCEDURES FOR SUBMITTING CLAIMS

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

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

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

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

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

TIMELY FILING

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

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

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

HOW HEALTH BENEFITS ARE CALCULATED

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

Claims for covered benefits are paid according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

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

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. Refer to the U&C level being allowed by the Centers for Medicare and Medicaid Services on the Provider Network provision, see surgery and assistant surgeon under the Covered Benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

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

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

TIMELINES FOR INITIAL BENEFIT DETERMINATION

Please refer to the Dignity Health Summary Plan Description "SPD." A copy of this document can be located at dignityhealthmember.org/totalrewards.

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

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

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.

- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational or Unproven.
- Other reasons as stated elsewhere in this Medical Plan Document.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

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

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

Please refer to the Dignity Health Summary Plan Description "SPD." A copy of this document can be located at dignityhealthmember.org/totalrewards.

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

First Appeal: Within 180 days after receiving a notice that Your claim has been denied (or within 180 days of the date You were entitled to consider Your request denied, if You do not receive a denial notice), You or Your authorized representative may submit a written request for review of the denial to the claims administrator for Your benefit plan as shown below:

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

Send Pharmacy appeals to:
OPTUMRX
PO BOX 8082
WAUSAU WI 54402-8082

During the appeal process, You have the right to present evidence and testimony pertaining to the claim and You have the right to review Your claim file. You should submit all of the issues, comments, additional information, and relevant documents that You want considered with Your request for review to the claims administrator.

The claims administrator will make a full and fair review of Your request and may ask for additional information. Your request for review of the denial will be conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial benefit determination nor a subordinate of such individual. The review of the denied claim will not afford that denial any deference.

If the claims administrator relies upon any new or additional evidence that was considered, relied upon, or generated during the review of Your claim, You will be provided, free of charge, with this new or additional evidence. The evidence will be provided to You sufficiently in advance of the Plan's final decision to allow You a reasonable opportunity to respond to the new evidence.

Similarly, if the claims administrator relies upon any new or additional rationale when deciding Your appeal, You will be provided, free of charge, with this new or additional rationale. The rationale will be provided to You sufficiently in advance of the Plan's final decision to allow You a reasonable opportunity to respond to the new rationale.

You will receive written notification of the decision on Your appeal within:

- 72 hours, for urgent health care claims (see definition of urgent health care claims under "Key Terms");
- 15 days, for claims that require pre-admission certification or continued stay approval before medical care is received;
- 30 days for all other claims (those that are not urgent or do not require prior approval).

If Your appeal is denied, the notice will explain:

- Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to You as soon as practicable, along with their corresponding meaning;
- A statement of the specific reason(s) for the decision, including:
  - The Plan's denial code and its corresponding meaning and
  - The Plan's standard, if any, that was used in denying the claim;
- The Plan provisions on which it is based;
- A statement describing the availability of and how to initiate a second appeal, the availability of an external review and Your right to obtain information about such procedures;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to Your claim;
- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes; and
- A statement that "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency."

Second Appeal: Within 180 days of receiving a notice from the claims administrator (or within 180 days of the date You were entitled to consider Your request denied, if You do not receive a denial notice from the claims administrator) that Your claim has been denied, You or Your authorized representative may submit a written request for review of the denial to the claims administrator as shown below.

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

Send Pharmacy appeals to:
OPTUMRX
PO BOX 8082
WAUSAU WI 54402-8082

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

During the appeal process, You have the right to present evidence and testimony pertaining to the claim and You have the right to review Your claim file.

If the claims administrator relies upon any new or additional evidence that was considered, relied upon, or generated during the review of Your claim, You will be provided, free of charge, with this new or additional evidence. The evidence will be provided to You sufficiently in advance of the Plan's final decision to allow You a reasonable opportunity to respond to the new evidence.

Similarly, if the claims administrator relies upon any new or additional rationale when deciding Your appeal, You will be provided, free of charge, with this new or additional rationale. The rationale will be provided to You sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new rationale.

The claims administrator will perform a second full and fair review of Your request and may ask for additional information. You will receive written notification of the decision on Your appeal, within:

- 72 hours, for urgent health care claims (see definition of urgent health care claims under "Key Terms").
- 15 days, for claims that require pre-admission certification or continued stay approval before medical care is received.
- 30 days for all other claims (those that are not urgent or do not require prior approval).

If Your appeal is denied, the notice will explain:

- Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to You as soon as practicable, along with their corresponding meanings;
- A statement of the specific reason(s) for the decision, including:
  - The Plan's denial code and its corresponding meaning; and
  - The Plan's standard, if any, that was used in denying the claim;
- The Plan provisions on which it is based;
- A statement describing the availability of an external review, any voluntary appeal procedures offered by the Plan, Your right to obtain information about such procedures, and how to initiate a voluntary appeal;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to Your claim;

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes;
- A statement that "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency"; and
- A statement of Your right to bring a civil action following a claim denial on review.

Voluntary Appeal

If Your prior two appeals have been denied in whole or in part, You have the right to seek a voluntary appeal, as explained below, or You may initiate an external review if You qualify for such a review or You can file a civil suit against the Plan.

Within 180 days of receiving a notice from the claims administrator (or within 180 days of the date You were entitled to consider Your request denied, if You do not receive a denial notice from the claims administrator) that Your claim has been denied, You or Your authorized representative may submit a written request for review of the denial to the Plan Administrator as shown below:

EMPLOYEE BENEFITS ADMINISTRATIVE COMMITTEE
DIGNITY HEALTH
3033 N 3RD AVE
PHOENIX AZ 85013

During the appeal process, You have the right to present evidence and testimony pertaining to the claim and You have the right to review Your claim file. You should submit all of the issues, comments, additional information, and relevant documents that You want considered with Your request for review to the Plan Administrator.

This is a voluntary appeal. This means that You may choose to have the Plan Administrator review Your claim that was denied by the claims administrator OR You may bring a civil action instead. If You choose to follow the procedures of this voluntary 3rd level of appeal, You continue to have the right to bring a civil action if Your claim is denied by the Plan Administrator.

If the Plan Administrator relies upon any new or additional evidence that was considered, relied upon, or generated during the review of Your claim, You will be provided, free of charge, with this new or additional evidence. The evidence will be provided to You sufficiently in advance of the Plan's final decision to allow You a reasonable opportunity to respond to the new evidence.

Similarly, if the Plan Administrator relies upon any new or additional rationale when deciding Your appeal, You will be provided, free of charge, with this new or additional rationale. The rationale will be provided to You sufficiently in advance of the Plan's final decision to allow You a reasonable opportunity to respond to the new rationale.

You will receive written notification of the final decision on your appeal from the Plan Administrator on the following basis:

- 72 hours, for urgent health care claims (see definition of urgent health care claims under "Key Terms");
- 15 days, for claims that require pre-admission certification or continued stay approval before medical care is received;
- 30 days for all other claims (those that are not urgent or do not require prior approval).

If You receive no response within these time frames, You may consider the appeal denied. If Your appeal is denied, the notice will explain:

- Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to You as soon as practicable, along with their corresponding meaning, and the treatment code and its corresponding meaning;
- A statement of the specific reason(s) for the decision, including:
  - The Plan's denial code and its corresponding meaning; and
  - The Plan's standard, if any, that was used in denying the claim;
- The Plan provisions on which it is based;
- A statement that you are entitled to receive, upon request and free of charge, all records relevant to Your claim, whether or not such records were considered in the appeals decision;
- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes; and
- A statement of Your right to an external review and to bring a civil action following a claim denial on review.

Deemed Exhaustion of Internal Claims and Appeals Processes

If You have been deemed to have exhausted the Plan's internal claims and appeals process, You may:

- Initiate an external review; or
- Pursue any remedies available under ERISA § 502 or state law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If any party responsible for reviewing Your claim or appeal (such as the claims administrator or Plan Administrator) fails to adhere to these claims procedures when reviewing Your claim or appeal, You will be deemed to have exhausted the Plan's internal claims and appeals process provided the failure is more than de minimis, it prejudices Your claim, is not due to good cause or matters beyond the Administrator's control, was not part of a good-faith exchange of information, and there has been a pattern or practice of not complying with the claims and appeals procedures. Within 10 days the Plan must explain why it believes that it meets these criteria so that You can make a judgment as to whether or not you have exhausted the Plan's internal claims and appeals process, thereby giving you the right to initiate an external review, or file a court action. If the external independent review organization or court rejects Your request for external review, then You can continue to pursue the Plan's internal claims and appeals process.

Avoiding Conflicts of Interest

The Plan Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of Plan benefits.

External Review

As required by the Patient Protection and Affordable Care Act, the Plan complies with the federal external review process. This means that for any claims initiated after September 20, 2011, You are eligible to have claim and appeal denials concerning medical judgment or rescission of coverage reviewed by an independent review organization and the decision reached through the external review is binding on the Plan. Rescission of coverage means a retroactive termination of medical plan coverage. Examples of decisions concerning medical judgment are determining whether care should be provided on an Outpatient or Inpatient basis, whether treatment by a specialist is Medically Necessary, or whether treatment involves Emergency care or is Urgent Care. The independent review organization will determine if Your request qualifies for an external review. Even though the Plan reserves the right to seek court action following the decision of the external reviewer, Your benefit claims will be paid in the meantime while the Plan seeks this judicial review. The Plan will pay the cost of external reviews; however, You may be required to pay a filing fee of no more than $25. That filing fee will be refunded to You if Your claim denial is reversed through the external review. Also, the filing fee will be waived if payment of the fee would impose an undue financial hardship. If the Plan imposes a filing fee for external reviews, the annual limit on filing fees will be $75.

The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of claim or appeal denial. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days following the date of receipt of the external review request, the independent review organization will complete a preliminary review of the request to determine whether:

- Your request is eligible for external review;
- The claimant has exhausted the plan's internal appeal process or if the claimant is deemed to have exhausted the internal appeals process; and
- The claimant has provided all the information and forms required to process an external review.

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

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

Within one business day after completion of the preliminary review, the independent review organization will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

FRAUD

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

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

Each Covered Person must:

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

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

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

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1.800.356.5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

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

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

Please refer to the Dignity Health Summary Plan Description "SPD." A copy of this document can be located at dignityhealthmember.org/totalrewards.

STATEMENT OF ERISA RIGHTS

Please refer to the Dignity Health Summary Plan Description “SPD.” A copy of this document can be located at dignityhealthmember.org/totalrewards.

PLAN AMENDMENT AND TERMINATION INFORMATION

Please refer to the Dignity Health Summary Plan Description “SPD.” A copy of this document can be located at dignityhealthmember.org/totalrewards.

GLOSSARY OF TERMS

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

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

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

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

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

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

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

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

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

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

Child (Children) means any of the following individuals with respect to an Employee: Employee's biological, adopted, step, legal guardianship Child(ren) and/or Children of a registered Domestic Partner, legally domiciled adult or adult tax Dependent through age 25; Employee's unmarried biological, adopted, step, legal guardianship Child(ren) and/or Children of a registered Domestic Partner who became mentally or physically disabled prior to age 26, who are incapable of self-sustaining employment and chiefly dependent upon the Employee for support (Social Security disability determination or Physician documented incapability of self-support due to disability is required).

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

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

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

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

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

Covered Person means an Employee or Dependent who is enrolled under this Plan.

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

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

Dependent means an eligible Dependent from one of the following categories:

- One adult from the following categories:
  - Spouse – legally married spouse, as defined by the law of the jurisdiction where the marriage was performed. Dignity Health will recognize it as a valid marriage even if the spouses reside in a state which does not recognize the marriage.
  - An adult tax Dependent – adult, over age 18, residing in the same home as the Employee, who is an IRS tax Dependent of the Employee and is not Medicare eligible.
  - Legally domiciled adult -- An individual who is over age 18, not Medicare eligible, is of the same or opposite sex, is in a committed relationship with a benefited employee, has been domiciled with the Employee for at least one year, who is not a blood relative, and neither the Employee or the LDA has a spouse or a registered domestic partnership with another adult.
- Dependent Child(ren):
  - Employee's biological, adopted, step, legal guardianship Child(ren) and/or Children of a registered Domestic Partner, legally domiciled adult or adult tax dependent through age 25.
  - Employee's unmarried biological, adopted, step, legal guardianship Child(ren) and/or Children of a registered Domestic Partner who became mentally or physically disabled prior to age 26, who are incapable of self-sustaining employment and chiefly dependent upon the Employee for support (Social Security disability determination or Physician documented incapability of self-support due to disability is required).

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

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

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

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in the Facility Specific Benefit Information (FSBI) document and the Dignity Health Summary Plan Description provided on dignityhealthmember.org/totalrewards. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

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

Employee – see the Eligibility and Enrollment section in the Facility Specific Benefit Information (FSBI) document provided on dignityhealthmember.org/totalrewards.

Enrollment Date means:

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

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

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

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

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

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

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

Gender Dysphoria means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Gender Dysphoria is a condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and gender identity. It is sometimes known as gender identity disorder (GID), gender incongruence or transgenderism.

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

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

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

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

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

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

Hospital means a facility that:

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

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate. The term "Hospital" does not include services provided in facilities operating as residential treatment centers.

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

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

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

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

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

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

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

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

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

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

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

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

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

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

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

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

- In accordance with Generally Accepted Standards of Medical Practice; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- 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 Illness, Injury, disease or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

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

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

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

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

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness, or death.

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

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

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

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the “Essential Health Benefit” definition.

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

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

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

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

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

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

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

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

Plan means the DIGNITY HEALTH Group Health Benefit Plan.

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

Plan Sponsor means an employer who sponsors a group health plan.

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

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

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

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

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

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

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

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

Specialist means a Physician or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

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

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

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video or data communications.

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

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

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

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

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Disease – Clinical Modification manual (ICD-CM) in the following categories:

    - Personality disorders; or
    - Behavior and impulse control disorders; or
    - “V” codes.

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

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

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan.

You / Your means the Employee.