

LITHKO CONTRACTING, LLC

Health Benefit Summary Plan Description
7670-00-430093

Revised 01-01-2026

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

Table of Contents

INTRODUCTION.....	1
PLAN INFORMATION	2
MEDICAL SCHEDULE OF BENEFITS	4
QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS.....	12
TRANSPLANT SCHEDULE OF BENEFITS	19
TRANSPLANT SCHEDULE OF BENEFITS	20
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	21
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	23
ELIGIBILITY AND ENROLLMENT	25
SPECIAL ENROLLMENT PROVISION	29
TERMINATION	31
HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION	33
COBRA CONTINUATION OF COVERAGE.....	37
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994.....	45
PROTECTION FROM BALANCE BILLING.....	46
PROVIDER NETWORK.....	48
COVERED MEDICAL BENEFITS	50
TELADOC HEALTH SERVICES.....	60
KAIA VIRTUAL EXERCISE THERAPY	62
LEVEL2 ASSURED VALUE PROGRAM.....	63
HOME HEALTH CARE BENEFITS.....	64
TRANSPLANT BENEFITS	65
PRESCRIPTION BENEFITS	68
VISION CARE BENEFITS	70
HEARING AID BENEFITS.....	71
BEHAVIORAL HEALTH BENEFITS.....	72
UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER	74

CENTERS OF EXCELLENCE.....	78
COORDINATION OF BENEFITS	79
RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET	83
GENERAL EXCLUSIONS	86
CLAIMS AND APPEAL PROCEDURES	91
FRAUD.....	101
OTHER FEDERAL PROVISIONS	102
HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION	104
STATEMENT OF ERISA RIGHTS	108
PLAN AMENDMENT AND TERMINATION INFORMATION	110
GLOSSARY OF TERMS	111

LITHKO CONTRACTING, LLC
GROUP HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the LITHKO CONTRACTING, LLC Health Benefits Plan. As a valued Employee of LITHKO CONTRACTING, LLC, we are pleased to sponsor the Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

LITHKO CONTRACTING, LLC is named the Administrator for the 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 Express Scripts for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under the Plan, as 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, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

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

Individuals covered under the Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

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

This document becomes effective on June 1, 2011.

PLAN INFORMATION

Plan Name	LITHKO CONTRACTING, LLC GROUP BENEFIT PLAN Building Your Benefits Health & Welfare Benefit Plan
Name And Address Of Employer	LITHKO CONTRACTING, LLC 2958 E CRESCENTVILLE RD WEST CHESTER OH 45069
Name, Address And Phone Number Of Plan Administrator	LITHKO CONTRACTING, LLC 2958 E CRESCENTVILLE RD WEST CHESTER OH 45069 855-413-0916
Named Fiduciary	LITHKO CONTRACTING, LLC
Employer Identification Number Assigned By The IRS	43-1214734
Plan Number Assigned By The Plan	505
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	LITHKO CONTRACTING, LLC 2958 E CRESCENTVILLE RD WEST CHESTER OH 45069
	Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions
	Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31

ERISA And Other Federal Compliance

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

Discretionary Authority

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

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001 PPO

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

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

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

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

Notes: 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.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: <ul style="list-style-type: none">• Per Person• Per Family<ul style="list-style-type: none">– Individual Embedded Deductible	\$1,500 \$3,000 \$1,500	\$3,000 \$6,000 \$3,000
Note: Embedded Deductible Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than His Or Her Embedded Individual Deductible Amount.		
Plan Participation Rate, Unless Otherwise Stated Below: <ul style="list-style-type: none">• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Total Out-Of-Pocket Maximum: Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum. <ul style="list-style-type: none">• Per Person• Per Family<ul style="list-style-type: none">– Individual Embedded Out-Of-Pocket Maximum	\$4,000 \$8,000 \$4,000	\$8,000 \$16,000 \$8,000
Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than His Or Her Embedded Individual Out-Of-Pocket Maximum Amount.		

	IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation: • Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: • Paid By Plan After Deductible	100% (Deductible Waived)	60%
Contraceptive Methods Approved By The FDA And Contraceptive Counseling:		
For Men: • Paid By Plan After Deductible	80%	60%
For Women: • Paid By Plan	100% (Deductible Waived)	60%
Dialysis: • Paid By Plan After Deductible	80%	No Benefit
Durable Medical Equipment: • Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Emergency Room Only: • Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan	\$300 100% (Deductible Waived)	\$300 100% (Deductible Waived)
Emergency Physicians Only: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Urgent Care: • Co-pay Per Visit • Paid By Plan	\$50 100% (Deductible Waived)	Not Applicable 60%
Walk-In Retail Health Clinics: • Co-pay Per Visit • Paid By Plan	\$20 100% (Deductible Waived)	Not Applicable 60%
Expanded Preventive List For Specific Chronic Conditions – Refer To The Covered Medical Benefits Section For Details:		
Antiresorptive Therapy For The Diagnosis Of Osteoporosis And/Or Osteopenia: • Paid By Plan	100% (Deductible Waived)	60%
Beta-Blockers For The Diagnosis Of Congestive Heart Failure: • Paid By Plan	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Blood Pressure Monitor For The Diagnosis Of Hypertension: • Paid By Plan	100% (Deductible Waived)	60%
Retinopathy Screening, Glucometer, And Hemoglobin A1C Testing For The Diagnosis of Diabetes: • Paid By Plan	100% (Deductible Waived)	60%
Peak Flow Meter And Inhaled Corticosteroids For The Diagnosis Of Asthma: • Paid By Plan	100% (Deductible Waived)	60%
International Normalized Ratio (INR) Testing For The Diagnosis Of Liver Disease And/Or Bleeding Disorders: • Paid By Plan	100% (Deductible Waived)	60%
Low-Density Lipoprotein (LDL) Testing For The Diagnosis Of Heart Disease: • Paid By Plan	100% (Deductible Waived)	60%
Beta-Blockers For The Diagnosis Of Coronary Artery Disease: • Paid By Plan	100% (Deductible Waived)	60%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: • Paid By Plan After Deductible	80%	60%
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.	120 Visits	
Hospice Care Benefits:		
Hospice Services: • Paid By Plan After Deductible	80%	60%
Bereavement Counseling: • Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services Only:		
• Paid By Plan After Deductible	80%	60%
Outpatient Physician Charges Only:		
• Co-pay Per Visit	\$30	Not Applicable
• Paid By Plan	100% (Deductible Waived)	60%
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Injectable Medication Not Covered Under Drug Card / Mail Order Only:		
• Co-pay Per Visit	\$30	Not Applicable
• Paid By Plan	100% (Deductible Waived)	60%
Manipulations:		
• Paid By Plan After Deductible	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits. Medical Necessity Review Is Based On Chiropractic Designation And Procedure Code.		
Maternity:		
Routine Prenatal Services:		
• Paid By Plan	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Mental Health And Substance Use Disorder Benefits:		
Inpatient Services / Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Residential Treatment:		
• Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization Physician Charges Only:		
• Co-pay Per Visit	\$30	Not Applicable
• Paid By Plan	100% (Deductible Waived)	60%
Office Visit:		
• Co-pay Per Visit	\$30	Not Applicable
• Paid By Plan	100% (Deductible Waived)	60%
Physician Office Services:		
• Co-pay Per Visit – Primary Care Physician	\$30	Not Applicable
• Co-pay Per Visit – Specialist	\$50	Not Applicable
• Paid By Plan	100% (Deductible Waived)	60%
Office Surgery:		
• Paid By Plan After Deductible	80%	60%
Allergy Injections And Sublingual Drops Billed Without An Office Visit:		
• Co-pay Per Visit	\$30	Not Applicable
• Paid By Plan	100% (Deductible Waived)	60%
Allergy Injections And Sublingual Drops Billed With An Office Visit:		
• Paid By Plan	100% (Deductible Waived)	60%
Office Imaging:		
• Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	60%
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Foreign Travel Immunizations: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Pelvic Exams And Pap Tests: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams: • Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Eye Exams And Glaucoma Testing: • Maximum Exams Per Calendar Year • Co-pay Per Visit • Paid By Plan	1 Exam \$30 100% (Deductible Waived)	\$30 100% (Deductible Waived)
Eye Refractions: • Maximum Exams Per Calendar Year • Co-pay Per Visit • Paid By Plan	1 Exam \$30 100% (Deductible Waived)	\$30 100% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Paid By Plan	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: <ul style="list-style-type: none"> ➤ 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 	100% (Deductible Waived)	60%
*These Services May Also Apply To Men.		
Sterilizations:		
For Men: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
For Women: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	60%
Teladoc Health Services:		
24/7 Care: <ul style="list-style-type: none"> • Co-pay Per Occurrence • Paid By Plan 	\$10 100% (Deductible Waived)	
Mental Health: <ul style="list-style-type: none"> • Co-pay Per Occurrence • Paid By Plan 	\$10 100% (Deductible Waived)	
Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.		
Temporomandibular Joint Disorder Benefits:		
Diagnostic: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan 	\$50 100% (Deductible Waived)	Not Applicable 60%
Surgical Treatment: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Non-Surgical Treatment: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan 	\$50 100% (Deductible Waived)	Not Applicable 60%
Therapy Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits.		

	IN-NETWORK	OUT-OF-NETWORK
Venipuncture: • Paid By Plan	100% (Deductible Waived)	60%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year • Maximum Benefit Per Calendar Year • Paid By Plan	\$500 1 Wig 100% (Deductible Waived)	100% (Deductible Waived)
All Other Covered Expenses: • Paid By Plan After Deductible	80%	60%

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family

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

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

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

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

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

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

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

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.</i> <ul style="list-style-type: none">• Single Coverage• Family Coverage	\$3,000 \$6,000	\$6,000 \$12,000
 <i>Note: If Family Coverage Is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.</i>		
Plan Participation Rate, Unless Otherwise Stated Below: <ul style="list-style-type: none">• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Total Out-Of-Pocket Maximum: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.</i> <ul style="list-style-type: none">• Single Coverage• Family Coverage	\$5,000 \$8,700	\$10,000 \$20,000
 <i>Note: If Family Coverage Is Elected, The Full Family Out-Of-Pocket Maximum Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.</i>		

	IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation: • Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: • Paid By Plan	100% (Deductible Waived)	60%
Contraceptive Methods Approved By The FDA And Contraceptive Counseling:		
For Men: • Paid By Plan After Deductible	80%	60%
For Women: • Paid By Plan	100% (Deductible Waived)	60%
Dialysis: • Paid By Plan After Deductible	80%	No Benefit
Durable Medical Equipment: • Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Emergency Room / Emergency Physicians: • Paid By Plan After In-Network Deductible	80%	80%
Urgent Care: • Paid By Plan After Deductible	80%	60%
Walk-In Retail Health Clinics: • Paid By Plan After Deductible	80%	60%
Expanded Preventive List For Specific Chronic Conditions – Refer To The Covered Medical Benefits Section For Details:		
Antiresorptive Therapy For The Diagnosis Of Osteoporosis And/Or Osteopenia: • Paid By Plan	100% (Deductible Waived)	60%
Beta-Blockers For The Diagnosis Of Congestive Heart Failure: • Paid By Plan	100% (Deductible Waived)	60%
Blood Pressure Monitor For The Diagnosis Of Hypertension: • Paid By Plan	100% (Deductible Waived)	60%
Retinopathy Screening, Glucometer, And Hemoglobin A1C Testing For The Diagnosis of Diabetes: • Paid By Plan	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Peak Flow Meter And Inhaled Corticosteroids For The Diagnosis Of Asthma: • Paid By Plan	100% (Deductible Waived)	60%
International Normalized Ratio (INR) Testing For The Diagnosis Of Liver Disease And/Or Bleeding Disorders: • Paid By Plan	100% (Deductible Waived)	60%
Low-Density Lipoprotein (LDL) Testing For The Diagnosis Of Heart Disease: • Paid By Plan	100% (Deductible Waived)	60%
Beta-Blockers For The Diagnosis Of Coronary Artery Disease: • Paid By Plan	100% (Deductible Waived)	60%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Paid By Plan After Deductible	80%	60%
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.	120 Visits	
Hospice Care Benefits:		
Hospice Services: • Paid By Plan After Deductible	80%	60%
Bereavement Counseling: • Paid By Plan After Deductible	80%	60%
Hospital Services:		
Pre-Admission Testing: • Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate: • Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges: • Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Advanced Imaging Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges: • Paid By Plan After Deductible	80%	60%
Physician Clinic Visits In An Outpatient Hospital Setting: • Paid By Plan After Deductible	80%	60%
Injectable Medication Not Covered Under Drug Card / Mail Order Only: • Paid By Plan After Deductible	80%	60%
Manipulations: • Paid By Plan After Deductible	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits. Medical Necessity Review Is Based On Chiropractic Designation And Procedure Code.		
Maternity:		
Routine Prenatal Services: • Paid By Plan	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery, And Postnatal Care: • Paid By Plan After Deductible	80%	60%
Mental Health And Substance Use Disorder Benefits: • Paid By Plan After Deductible	80%	60%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting:		
This Section Does Not Apply To: ➤ Preventive / Routine Services ➤ Manipulation Services Billed By Any Qualifying Provider ➤ Dental Services Billed By Any Qualifying Provider ➤ Therapy Services Billed By Any Qualifying Provider ➤ Any Services Billed From An Outpatient Hospital Facility Except For Physician Clinic Visits In An Outpatient Hospital Setting • Paid By Plan After Deductible	80%	60%
Physician Office Services: • Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	60%
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	60%
Foreign Travel Immunizations:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Pelvic Exams And Pap Tests:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams:		
• Paid By Plan	100% (Deductible Waived)	60%
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:		
• Paid By Plan	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: <ul style="list-style-type: none"> ➤ Screening For Gestational Diabetes ➤ Papillomavirus DNA Testing* ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-Deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies, And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* <ul style="list-style-type: none"> • Paid By Plan <p>*These Services May Also Apply To Men.</p>	100% (Deductible Waived)	60%
Sterilizations:		
For Men: <ul style="list-style-type: none"> • Paid By Plan After Deductible For Women: <ul style="list-style-type: none"> • Paid By Plan 	80%	60%
Teladoc Health Services:		
24/7 Care: <ul style="list-style-type: none"> • Copay Per Occurrence • Paid By Plan Mental Health: <ul style="list-style-type: none"> • Copay Per Occurrence • Paid By Plan <p>Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.</p>	\$10 100% (Deductible Waived)	\$10 100% (Deductible Waived)
Temporomandibular Joint Disorder Benefits:	80%	60%
Therapy Services:	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits.		
Vision Care Benefits:		
Eye Exam: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible Refraction: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible 	100% 1 Exam 100% 1 Exam 100%	100% 100% 100%

	IN-NETWORK	OUT-OF-NETWORK
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata:		
<ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Maximum Benefit Per Calendar Year • Paid By Plan After In-Network Deductible 	100% \$500 1 Wig	100%
All Other Covered Expenses:	80%	60%
<ul style="list-style-type: none"> • Paid By Plan After Deductible 		

TRANSPLANT SCHEDULE OF BENEFITS

Benefit Plan(s) 001 PPO

Transplant Services At A Designated Transplant Facility: Transplant Services: <ul style="list-style-type: none">• Paid By Plan After Deductible Travel And Housing: <ul style="list-style-type: none">• Maximum Benefit Per Transplant• Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	80% \$10,000 100% (Deductible Waived)
---	---

TRANSPLANT SCHEDULE OF BENEFITS

The program for Transplant Services At Designated Transplant Facilities is:

Optum

Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family

Transplant Services: Designated Transplant Facility:	
Transplant Services:	
• Paid By Plan After Deductible	80%
Travel And Housing:	
• Maximum Benefit Per Transplant	\$10,000
• Paid By Plan After Deductible	100%
Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 001 PPO

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 any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

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

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

If You have family coverage, any combination of covered family members 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 Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

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

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

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy out-of-network Co-pays and out-of-network Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with notification requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate.
- Chiropractic services.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family

DEDUCTIBLES

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

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

The Deductible amounts that the Covered Person Incurs for Covered Expenses, including covered Pharmacy expenses, will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

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

PLAN PARTICIPATION

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

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

ANNUAL OUT-OF-POCKET MAXIMUMS

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

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

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

The eligible out-of-pocket expenses that the Covered Person Incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

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

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

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

WAITING PERIOD

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

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 90 consecutive days of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this **LITHKO CONTRACTING, LLC Health Benefits Plan**. **The Waiting Period will be satisfied for a person who has worked for a temporary agency on a LITHKO CONTRACTING, LLC assignment for 90 or more consecutive days and 30 hours or more per week.** Benefits for this co-worker will begin on the first day of work as a LITHKO CONTRACTING, LLC Co-worker.

LEAVE POLICY

This Leave Policy covers Personal Leaves and Temporary Layoffs that exceed five (5) continuous days. These leaves are granted only in cases not covered by any other policy for leaves of absence and require manager approval.

PERSONAL LEAVE (Voluntary)

A regular full-time co-worker who has completed 90 days of service may be granted a personal leave, without pay, not to exceed six weeks.

Some typical reasons for granting such leaves include: illness in the family not covered under another leave policy, continuing education or other extenuating personal needs. Lithko Contracting, LLC reserves the right to require written substantiation of the conditions prompting the need for such a leave of absence.

Return from Personal Leave

There is no job guarantee with a Personal Leave. If Lithko replaces the co-worker on leave with another regular co-worker, the co-worker returning from leave may apply for rehire.

TEMPORARY LAYOFF (Involuntary)

A regular full-time co-worker who has completed 90 days of service may be placed on temporary layoff, without pay, not to exceed eight weeks.

Recall from Temporary Layoff

Co-worker recall is determined by business need. Recall eligibility is determined by the co-workers demonstrated skills and qualifications to perform the job, attendance, and disciplinary records.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased employees.
- An Independent Contractor as defined in this Plan.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will be deemed to have met the eligibility requirements for the resulting stability period as required by the (ACA) regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment. See the Special Enrollment section.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. Coverage under this Plan is not available to the spouse of an eligible Employee if the spouse works full-time and is eligible for health coverage through his or her own employer.
- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:
 - A natural biological Child;
 - A step Child;
 - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
 - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
 - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
- A Dependent does not include the following:
 - A foster Child;
 - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;

- A grandchild;
- Domestic Partners;
- Any other relative or individual unless explicitly covered by this Plan;
- A Dependent Child who is covered as a Dependent of another Employee at this company.

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

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

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

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

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

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

and the Dependent Child fits the following category:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 60 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:
 - The Dependent must not be able to hold a self-sustaining job due to the disability; and
 - Proof must be submitted as required (Notice of Award of Social Security Income is acceptable); and
 - The Employee must still be covered under this Plan.

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

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

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within Your Waiting Period, Your coverage will become effective the **91st** day following Your date of hire; or
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 60 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

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

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 60 days of acquiring the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 60 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

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

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

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

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

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

SPECIAL ENROLLMENT PROVISION
Under the Health Insurance Portability and Accountability Act

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

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and
- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health plan or health insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage is offered; or
 - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
 - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 60 calendar days after the date the other coverage ended.

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

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

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 60 calendar days of marriage, birth, adoption or Placement for Adoption.

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

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

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

RELATION TO SECTION 125 CAFETERIA PLAN

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

TERMINATION

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

EMPLOYEE'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The end of the stability period as defined by the Affordable Care Act (ACA) in which You became a member of a non-covered class, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan; or.
- The last day of the month in which Your regular hours of work are reduced to the point where You are no longer a **full-time co-worker under the employer's policies**; or
- The last day of the month in which You are on an extended leave of absence **approved by the company for personal, non-medical reasons which extends beyond two weeks**; or
- The last day of the month in which You are on an extended leave of absence for medical reasons and that leave goes beyond the time for which You are eligible for FMLA **and You are not entitled to or You exhaust Your entitlement to short-term disability benefits (STD) under the employer's STD policy**.

Reinstatement Following Personal Leave or Temporary Layoff

Although not guaranteed, Lithko will make every effort to return a co-worker who has been granted a personal leave or placed on temporary layoff to the same position upon completion of the leave, or a comparable position within the same location.

- If a co-worker fails to return to work as scheduled, employment will be terminated.

Benefits Continuation

- A Co-worker may retain eligibility for coverage under Lithko sponsored plans if the co-worker is temporarily absent on an approved leave/layoff, with the expectation of returning to work following the approved leave/layoff.
- Lithko will continue to pay the employer contribution for the co-worker's Lithko sponsored plans while the co-worker is on unpaid leave/layoff. The co-worker and covered dependents are required to pay the co-worker contributions.

YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends except in the event that the Employee dies, coverage for the Dependent can continue until the end of the month after the month following the death of the Employee, provided that the Dependent pays the applicable contribution when due; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Eligibility and Enrollment Section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSON OF COVERAGE

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

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

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

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 52 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 52 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 52-week period, You will be treated as a new hire and will be required to meet all of the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

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

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

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

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

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

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

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;
- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources or Personnel office

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

COBRA CONTINUATION OF COVERAGE

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

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

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

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

INTRODUCTION

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

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

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

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

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

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

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

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

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

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

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

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

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

COBRA NOTICE PROCEDURES

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

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

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

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

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

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

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

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

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

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

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

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

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

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

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

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

PAYMENT FOR CONTINUATION COVERAGE

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

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

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

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

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

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

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

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

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

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

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

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.
- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

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

LENGTH OF CONTINUATION COVERAGE

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

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - The Employee's death.
 - The Employee's divorce or legal separation.
 - The former Employee's enrollment in Medicare.
 - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

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

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

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

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

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or

- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

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

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

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

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

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

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA CONTINUATION

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

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

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

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

DEFINITIONS

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

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

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

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

IF YOU HAVE QUESTIONS

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

The Plan Administrator:

LITHKO CONTRACTING, LLC
2958 E CRESCENTVILLE RD
WEST CHESTER OH 45069

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

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

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

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

USERRA NOTICE AND ELECTION

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

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

PAYMENT

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

EXTENDED COVERAGE RUNS CONCURRENT

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

PROTECTION FROM BALANCE BILLING

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

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

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

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

ALLOWED AMOUNTS

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

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

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

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

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

OUT-OF-NETWORK BENEFITS

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

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

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

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

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

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

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

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

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

PROVIDER NETWORK

The word "**Network**" means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, 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, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

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

UnitedHealthcare Choice Plus

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. 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.
- **The Program for Transplant Services at Designated Transplant Facilities is:**

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

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

- Non-air Ambulance transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered Services provided by a Physician (excluding surgeons) during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Wigs, toupees, and hairpieces will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

CONTINUITY OF CARE

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

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

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

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

COVERED MEDICAL BENEFITS

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

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent 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.

1. **Abortions (Elective).**
2. **Allergy Treatment** including: injections, testing and serum.
3. **Ambulance Transportation:**
 - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
 - Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.
4. **Anesthetics and their Administration.**
5. **Aquatic Therapy.** (See Therapy Services below)
6. **Augmentation Communication Devices** and related instruction or therapy.
7. **Autism Spectrum Disorders (ASD) Treatment.**

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

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

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).
8. **Blood Pressure Cuffs / Monitors.**
9. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.
10. **Breast Reductions** if Medically Necessary.

11. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.
12. **Cardiac Pulmonary Rehabilitation** Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.
13. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:
 - had a heart attack in the last 12 months; or
 - had coronary bypass surgery; or
 - a stable angina pectoris.Services covered 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.
14. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.
15. **Chiropractic Treatment.** Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.
16. **Circumcision** and related expenses when care and treatment meet the definition of Medically Necessary. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.
17. **Cleft Palate And Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.
18. **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.
19. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

The following contraceptives will be processed under the medical Plan:

 - Contraceptive mobile app subscription (e.g., Natural Cycles).
 - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
 - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.
20. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.
21. **Counseling Services** if Medically Necessary.

22. Dental Services include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants.
- 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.

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

24. Dialysis: Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. 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.

25. 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 is subject to review under the UMR CARE section of this SPD, if applicable.
- 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 towards 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 excluding 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, misuse, loss, or theft, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.

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

27. Expanded Preventive List for Specific Chronic Conditions: The following services will be covered when diagnosed with specific chronic conditions as indicated below and not covered under the Prescription Drug Benefits section of this SPD.

- Antiresorptive therapy for the diagnosis of osteoporosis and/or osteopenia.
- Beta-blockers for the diagnosis of congestive heart failure.
- Blood pressure monitor for the diagnosis of hypertension.
- Retinopathy screening, glucometer, and hemoglobin A1C testing for the diagnosis of diabetes.
- Peak flow meter and inhaled corticosteroids for the diagnosis of asthma.
- International normalized ratio (INR) testing for the diagnosis of liver disease and/or bleeding disorders.
- Low-density lipoprotein (LDL) testing for the diagnosis of heart disease.
- Beta-blockers for the diagnosis of coronary artery disease.

28. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must give obtain prior authorization for services in advance. (Refer to the UMR CARE section of this SPD). The following benefits are covered:

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

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

30. **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.
- Covered charges do not include Palliative Foot Care.

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

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

Genetic testing MUST meet the following requirements:

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

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

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

Generally, genetic testing is not covered for:

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

33. **Hearing Services** include exams, tests, services and supplies to diagnose and treat a medical condition.

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

35. **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: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
- **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. 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.

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

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

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

37. **Hospital Services (Outpatient).**

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

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

39. **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).

40. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

41. **Learning Disability:** Special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability except for services that should be legally provided by a school.

42. **Marriage Counseling** that is part of a behavioral health treatment plan.

43. **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.

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

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

- Charges for diagnostic services.
- Nutritional counseling by a registered dietician.

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

46. **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.

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

48. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. 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.

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

50. **Oral Surgery** includes:

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

51. **Orthognathic, Prognathic And Maxillofacial Surgery** when Medically Necessary.
52. **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.
53. **Oxygen And Its Administration.**
54. **Pharmacological Medical Case Management** (Medication management and lab charges).
55. **Physical Therapy.** (See Therapy Services below)
56. **Physician Services** for covered benefits.
57. **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.
58. **Prescription Medications** which are administered or dispensed as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.
59. **Preventive / Routine Care** as listed under the Schedule of Benefits.

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- 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;
 - Screening and counseling for interpersonal and domestic violence; and
 - Breast cancer genetic test counseling (BRCA) for women at high risk.

Please visit the following links for additional information:

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

60. 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.

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

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

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

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

Routine patient care costs for Qualifying Clinical Trials may include:

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

Routine costs for clinical trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);

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

62. Radiation Therapy and Chemotherapy.

63. Radiology and Interpretation Charges.

64. Reconstructive Surgery includes:

- 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.
- Surgery to restore bodily function that has been impaired by a congenital illness or anomaly, Accident, or from an infection or other disease of the involved part.

65. Respiratory Therapy. (See Therapy Services below)

66. 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.

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

68. Sleep Disorders if Medically Necessary.

69. Sleep Studies.

70. Speech Therapy. (See Therapy Services below)

71. Sterilizations (Voluntary).

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

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

74. Telehealth. Consultations made by a Covered Person to a Physician.

75. Telemedicine. (Refer to the Teladoc Health Services section of this SPD for more details.)

76. Temporomandibular Joint Disorder (TMJ) Services includes:

- Diagnostic services.
- Surgical treatment.
- 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.

77. 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.
- **Physical therapy** by a Qualified physical therapist.
- **Respiratory therapy** by a Qualified respiratory therapist.
- **Aquatic therapy** by a Qualified physical therapist.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

78. Tobacco Addiction: Preventive / Routine Care as required by applicable law.

79. Transplant Services (Refer to Transplant section of this SPD).

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

81. Urinary Drug Screenings.

82. Vision Care Services (Applies to Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family) (Refer to Vision Care section of this SPD).

83. X-ray Services for covered benefits.

TELADOC HEALTH SERVICES

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

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc Health may be used:

- When immediate care is needed.
- When considering the ER or urgent care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc Health can be used for the following types of conditions:

- **24/7 Care general medicine, including, but not limited to:**
 - Colds and flu
 - Allergies
 - Bronchitis
 - Pink eye
 - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

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

Teladoc Health may not be used for:

- Drug Enforcement Agency-controlled Prescriptions.
- Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc Health.

Mental Health Program

The Mental Health Program includes access to mental health providers who provide mental health consultations to Covered Persons by telephone or video conference. The Mental Health Program offers Covered Persons ongoing access to mental diagnostic services, talk therapy, and prescription medication management, when appropriate. The mental health providers are selected and engaged to provide mental health clinical intake assessments in accordance with mental health protocols and guidelines that are tailored to the telehealth industry.

Mental Health Consultations: In order for a Covered Person to receive a mental health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Mental Health Program. This disclosure may be completed either online or by telephone with a designated Mental Health Program representative. In addition, the Covered Person must also agree to Teladoc Health's Informed Patient Consent and Release Form confirming an understanding that the mental health provider is not obligated to accept the Covered Person as a patient. If the Covered Person fails to complete the Medical History Disclosure, the Covered Person will not have access to the mental health providers through the Mental Health Program.

Scheduling: Teladoc Health will provide the Covered Person with information identifying each mental health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each mental health provider to allow the Covered Person to choose the provider from whom they wish to receive treatment. The Covered Person may schedule consultations through either Teladoc Health's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different mental health provider. There are no limitations on the number of mental health consultations a Covered Person may receive under the Mental Health Program.

Individual Sessions: The initial mental health consultation is expected to be 45 minutes in length, on average followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the mental health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A mental health provider may determine that the treatment of a Covered Person's particular mental health issue would be managed more appropriately through in-person therapy. In such a case, the mental health provider will encourage the Covered Person to make an appointment for an in-person visit.

Clarifications: Unlike the consultations provided under the 24/7 Care general medicine program, the mental health consultations under the Mental Health Program:

- Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a mental health consultation with a mental health provider and the consultation must occur within a time period for which the mental health provider is scheduled to support the Mental Health Program.
- Are not intended to be cross-coverage consultations. Rather, the Mental Health Program is designed to make mental health providers available by telephone or video conference even when another mental health counselor is available to the Covered Person for an in-person visit.
- Are not intended to be provided in Emergency situations.
- Are not available for Teladoc Health therapy for Covered Persons under the age of 13.
- Are not available for Teladoc Health psychiatry for Covered Persons under the age of 18.

KAIA VIRTUAL EXERCISE THERAPY

Kaia Health is a digital therapy application that works with You to build a personal therapy program to address both the causes and the symptoms of Your pain offered at no cost to You. Age requirements may apply.

Once You sign up, You will immediately gain access to Kaia's clinically validated therapy, including:

- Personalized exercise.
- One-on-one coaching.
- Whole-person mind-body training.
- Wellness education.
- Advanced motion analysis technology.

You may access Kaia Virtual Exercise Therapy at www.startkaia.com/umr.

LEVEL2 ASSURED VALUE PROGRAM

Level2 Specialty Care is a disease management program that helps You work to lower Your average blood glucose and improve Your type 2 diabetes using fresh insights and virtual clinical care, all backed by expert support and empowering tools. As part of Your benefits, You have access to a modern diabetes care program at no cost to You that can help You improve Your type 2 diabetes.

To enroll in this program, You can sign up directly on the website at <https://mylevel2.com/join> or you can call the Level2 Enrollment Team at 844-302-2821.

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 UMR CARE section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform 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 registered dietician.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- 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 four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a therapist or a registered dietician.

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 UMR CARE section of this SPD for prior authorization requirements

DEFINITIONS

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

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

Designated Transplant Facility means a facility 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 and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated 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 Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be 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), which may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy 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 a donor if the recipient is also a Covered Person under this Plan)

If the Covered Person 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:
 - Hotel rental.

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.

TRANSPLANT EXCLUSIONS

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

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

- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven.
- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.
- 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 NCCN compendium.
- Expenses related to, or for, the purchase of any organ.

PREScription BENEFITS

Administered by Express Scripts

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

DEFINITIONS

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy means a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Brand means a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of Prescription Drug benefits under the Plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician. Drugs that are available without a Prescription are considered non-legend drugs.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Plan, except as otherwise provided by the Plan. Outpatient Prescription Drugs will be covered subject to the applicable Co-pay amounts and any limitations as stated in the Schedule of Benefits.

A Covered drug must meet Clinical Eligibility for Coverage, be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact Express Scripts.

The following are **excluded** through the Prescription Drug program (this list is **not** all-inclusive):

- Applicable exclusions listed under General Exclusions section of this SPD.
- Prescription products if a prior authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

This Plan does not coordinate Prescription benefits.

For any Prescription Drug questions, please contact Express Scripts at the following:

EXPRESS SCRIPTS
ONE EXPRESS WAY
ST LOUIS MO 63121
1-877-295-5629

VISION CARE BENEFITS

Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family

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

COVERED BENEFITS

- Eye exam.
- Refraction.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

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

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

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

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-866-926-6632, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhcheating.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered and fitted by the provider.

In the event that You have questions about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-866-926-6632 or visit uhcheating.com.

BEHAVIORAL HEALTH BENEFITS

MENTAL HEALTH BENEFITS

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

Covered Benefits

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

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

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

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

Additional Provisions And Benefits

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

SUBSTANCE USE DISORDER BENEFITS

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

Covered Benefits

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

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

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

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

Additional Provisions And Benefits

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

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

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

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

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

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

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

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

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

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

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

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

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

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization at the number on the back of Your ID card or complete a Prior Authorization search at www.umr.com before a Covered Person receives services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or Durable Medical Equipment rentals over \$500 **including prosthetic, orthotic, or orthopedic appliances**.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- **Chemotherapy**.
- **Dialysis (exclude dialysis out of network)**.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit [Specialty Injectable | UMR](#) for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- **Obesity-morbid non-surgical treatment**.
- **Growth hormone therapy**.
- **Radiation Therapy**.

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount a Covered Person may be required to pay if an authorization has not been completed prior to receiving certain services or prior to admissions as defined in this section. A penalty of \$500 may be applied 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 receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

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

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

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

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

CARE PROVISIONS

Complex Condition CARE

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

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.

Wellness CARE

Components of Wellness CARE are as follows:

Tobacco and Nicotine Coaching Program: The UMR Tobacco and Nicotine Coaching Program connects the participant with an experienced and certified personal CARE coach who assists in the development of a quit plan and establishment of specific reduction or cessation goals and strategies. In addition, the participant will receive printed educational materials.

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

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

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

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

CENTERS OF EXCELLENCE

Dialysis Network Services (DNS)

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

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

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

COORDINATION OF BENEFITS

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

(Applies to Benefit Plan(s) 001 PPO) The order of benefit determination rules determine which plan will pay first (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 Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

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

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

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, 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 shall 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 to use:

- 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 shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where 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 their employer's benefit plan.
- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).
- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.
- If one or more plans cover the same person as a Dependent Child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that covered either of the parents longer 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, 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 paragraph 3 (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 exception in the Medicare section.)
- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer 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 can 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 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.

(Applies to Benefit Plan(s) 001 PPO) The order of benefit determination rules determine which plan will pay first (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 Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

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

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

- This Plan generally pays first under the following circumstances:
 - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
 - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay 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 can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, 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 have 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 an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
- You or Your covered spouse have 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 primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it 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 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.

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

The right to reimbursement means that if it is alleged that a 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 covered benefit You received for that Illness or Injury.

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 arising out of any alleged wrongful or bad faith conduct by such person or entity.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused Covered Expenses 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 Your covered benefits, deny future covered benefits, take legal action against You, and/or set off from any future covered benefits the value of covered benefits we have 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, 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 or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party allegedly arising out of Illness or Injury and the Plan alleges some or all of those funds are due and owed to the Plan, You will hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon our request, You will assign to us 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 a lawsuit to recover the full amount of medical benefits paid on Your behalf out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in Your 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 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.
- No allocation of damages, settlement funds, or any other recovery, by You, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If a 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.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

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

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

1. **Abdominoplasty.**
2. **Acts Of War:** Injury or illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Acupuncture Treatment.**
4. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.
5. **Appointments Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy** unless provided by a Qualified physical therapist.
7. **Assistance With Activities of Daily Living.**
8. **Assistant Surgeon Services**, unless determined Medically Necessary by 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. **Biofeedback Services.**
12. **Blood:** Blood donor expenses.
13. **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.
14. **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.
15. **Claims** received later than 12 months from the date of service.
16. **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
 - Sexual/gender identity disorders; or
 - Behavior and impulse control disorders; or
 - "V" codes (refer to Marriage Counseling within the Covered Medical Benefits section of this SPD).
17. **Contraceptive Products and Counseling**, unless covered elsewhere in this SPD.

18. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.
19. **Counseling Services** in connection with financial, marriage **or family** counseling.
20. **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.
21. **Custodial Care** as defined in the Glossary of Terms of this SPD.
22. **Dental Services**, unless covered elsewhere in this SPD.
23. **Developmental Delays:** Occupational, physical, or speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy.
24. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.
25. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.
26. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
27. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.
28. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, or the Negotiated Rate. This exclusion does not apply to payments that may be required under the No Surprises Act.
29. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.
30. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.
31. **Family Planning:** Consultation for family planning.
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 (Podiatry):** Routine foot care.
34. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to and including, gender transition surgery
35. **Growth Hormones**, unless covered elsewhere in this SPD.

36. Hearing Services:

- Purchase or fitting of hearing aids unless covered elsewhere in this SPD.
- Implantable hearing devices unless covered elsewhere in this SPD.

37. Home Births and associated costs.

38. 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.

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

40. 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.

41. Lamaze Classes or other child birth classes.

42. Liposuction regardless of purpose.

43. 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.

44. Mammoplasty or Breast Augmentation unless covered elsewhere in this SPD.

45. Marriage Counseling, unless covered elsewhere in this SPD.

46. Massage Therapy.

47. Maximum Benefit. Charges in excess of the Maximum Benefit allowed by the Plan.

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

49. Nocturnal Enuresis Alarm.

50. Non-Custom-Molded Shoe Inserts.

51. 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.

52. **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.

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

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

55. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the covered benefits.

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

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

58. **Personal Comfort:** Services or supplies for personal [hygiene](#), comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

59. **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.

60. **Prescription Medication**, which is administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's Prescription.

61. **Private Duty Nursing Services.**

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

63. **Respite Care.**

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

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

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

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

68. **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.

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

70. **Services Provided by a Close Relative**, unless covered elsewhere in this SPD. See Glossary of Terms of this SPD for definition of Close Relative.

71. **Sex Therapy.**

72. **Sexual Function:** non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

73. **Standby Surgeon Charges.**

74. **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.

75. **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.

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

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

78. **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.

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

80. **Vision Care** unless covered elsewhere in this SPD.

81. **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.

82. **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.

83. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

84. **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. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

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

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

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 whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

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

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

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents 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, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are 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 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 paid date is not known.

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

- Covered Person/patient 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 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, auto accident, or other 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. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary 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 to explain 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 services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this Plan. If it 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 it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

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

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

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.

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

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

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

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

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For 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 on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

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

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 can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of Plan.
- Termination of the Plan.
- 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.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person 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 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 was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

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

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under Section 502(a) of ERISA.

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

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed.

Send Post Service Claim Medical appeals to:

UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical Appeals to:

UHC APPEALS – UMR
PO BOX 400046
SAN ANTONIO TX 78229

EXPRESS SCRIPTS
ONE EXPRESS WAY
ST LOUIS MO 63121

TIME PERIODS FOR MAKING DECISION ON APPEALS

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

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

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

RIGHT TO EXTERNAL REVIEW

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

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a Wellness Program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
 - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
 - Whether a claim for items and services was furnished by a non-network provider at a network facility;
 - Whether an individual gave informed consent to waive the protections under the No Surprises Act;
 - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
 - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

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

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

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

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

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

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

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

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

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

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

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

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

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

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

LEGAL ACTIONS FOLLOWING APPEALS

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

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

- Made in error; or
- Made after the date the person 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 that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent 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 termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons 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 form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on Your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- 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 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.
- Any additional period of coverage provided by the Employer as stated in the Termination section of this SPD.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

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

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

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

- Mental Health Parity Act.
- The 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.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by ERISA.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

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

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

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

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

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

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

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan -related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan 's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Director of Human Resources, Benefits Manager, Benefits Administrator, Cornerstone

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;

- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons shall have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.
- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to \$110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, contact the Plan Administrator. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

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

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

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

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

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

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

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

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

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

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

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

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

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

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or
- Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

- In an Emergency situation; or
- When deemed Medically Necessary, which is to the closest facility most able to provide the specialized treatment required; and the most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

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

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

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

Close Relative means a member of the immediate family. Immediate family includes a husband or wife, birth or adoptive parent, Child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild.

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

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 a Qualifying Event.

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

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

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

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist 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 healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

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

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

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

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

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the first day of the Waiting Period, whichever is earlier.
- For anyone who enrolls under the Special Enrollment Provision, the Enrollment Date is the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the 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 and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- 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 (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in 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 includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one 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-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

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

Health Savings Account (HSA) (Applies to Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family) means a tax-exempt account administered by a qualified HSA trustee or custodian, established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a Qualified High Deductible Health Plan (QHDHP), has no other impermissible coverage under IRS rules, is not entitled to benefits under Medicare, and is not claimed as a Dependent on another person's tax return. See Qualified High Deductible Health Plan (QHDHP).

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the 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; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and 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 which 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 Covered Persons 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 a day, seven days a 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; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency; or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It 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, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. 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.

Incurred means the date the service or treatment is given, the supply is received or the 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 the work gets done. 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 shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done 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 done to prepare for induced conception; surgical reversal of a sterilized state which 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 which 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. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

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/Guardian means the individual is 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.

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

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

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

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, Substance Use Disorder, disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and
- Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

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

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall 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 Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

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

Mental Health Disorder means any disease or condition within the mental health or psychiatric diagnostic categories listed in the mental, behavioral, and neurodevelopment disorders in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

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

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

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

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

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, 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 Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is 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 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 preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

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

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed 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 LITHKO CONTRACTING, LLC Group Health Benefit Plan.

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

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

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug, that could be a medication or supply for the person for whom 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 prescribed. It must also identify the name, strength, quantity and the 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 Preventative / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

(Applies to Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family) For a Qualified High Deductible Health Plan (QHDHP), Preventive / Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a QHDHP without the Covered Person satisfying the minimum Deductible under the Plan.

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 or certified by the state in which the provider practices.

Qualified High Deductible Health Plan (QHDHP) (Applies to Benefit Plan(s) 003 HDHP – Single, 004 HDHP – Family) means a health plan that meets the IRS requirements of a High Deductible Health Plan with respect to Deductibles and out-of-pocket amounts for the purpose of being able to contribute to a Health Savings Account (HSA). See Health Savings Account (HSA).

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

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

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

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

Substance Use Disorder means any disease or condition that falls under the diagnostic categories as a mental or behavioral disorder due to psychoactive substance use listed in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

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

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

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

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

Temporomandibular Joint Disorder (TMJ) shall mean 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) is 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 is determined by the Plan in its sole discretion and generally means:

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

Urgent Care is 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 an Injury or Illness that requires immediate care but is 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 can become effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this.

You, Your means the Employee.