

# Summary Plan Description

## **GEICO Corporation Alaska Out of Area Plan**

Effective: January 1, 2021  
Group Number: 755393





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## SECTION 1 - HOW THE PLAN WORKS

**What this section includes:**

- Summary Plan Description;
- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

### Summary Plan Description (SPD)

The Summary Plan Description (SPD) describes the health Benefits available to you and your covered family members under the GEICO Corporation Medical, Dental and Vision Care Plan ("Plan"). It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

### Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay.

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide an In-Network Benefit level or an Out-of-Network Benefit level.

UnitedHealthcare arranges for health care providers to participate in a Network. Depending on the geographic area, you may have access to In-Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from an In-Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from an Out-of-Network provider because the Eligible Expense may be a lesser amount.

You may have access through UnitedHealthcare's Shared Savings Program to Out-of-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under the Plan.

UnitedHealthcare is the Plan's Claims Administrator for medical benefit services. CVS/caremark is the claims administrator for prescription drug benefits. GEICO Corporation is the Plan Sponsor and has appointed the Benefits Administrative Committee as the Plan Administrator.

### ***In-Network Providers***

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of In-Network providers free of charge. Keep in mind, a provider's In-Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

In-Network providers are independent practitioners and are not employees of GEICO Corporation or UnitedHealthcare. It is your responsibility to select your provider.

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

Do not assume that an In-Network provider's agreement includes all Covered Health Services. Some In-Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some In-Network providers choose to be an In-Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

#### **Looking for an In-Network Provider?**

In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

### ***Designated Providers***

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

## Eligible Expense

The Plan Sponsor has appointed UnitedHealthcare as Claims Administrator to adjudicate claims for benefits under the Plan.

Eligible Expenses are the amounts UnitedHealthcare, as Claims Administrator, determines that the Plan will pay for Benefits. For Covered Health Services provided by an Out-of-Network provider, you will be responsible to the Out-of-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Out-of-Network Benefits, payment for the Eligible Expense will be made to the Associate, and it is your responsibility to pay the provider for any difference between the amount the provider bills you and the amount the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Plan's reimbursement policy guidelines, as administered by UnitedHealthcare and described in this SPD.

Eligible Expenses are based on the following:

- When Covered Health Services are received from an In-Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from an Out-of-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are negotiated by UnitedHealthcare or an amount permitted by law.
- When Covered Health Services are received from an Out-of-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the Out-of-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
    - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service or data resources of competitive fees in a geographic area are not available, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable

scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at [www.myuhc.com](http://www.myuhc.com) for information regarding the vendor that provides the applicable gap fill relative value scale information.

**IMPORTANT NOTICE:** Out-of-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

**Don't Forget Your ID Card**

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you lose your UnitedHealthcare card or need additional cards, call UnitedHealthcare at 1-855-434-2684.

**Annual Deductible**

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

**Copayment**

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays for medical services count toward the medical Out-of-Pocket Maximum. Copays for prescription drugs do not count toward the medical Out-of-Pocket Maximum; there is a separate prescription drug Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense for a medical service is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

**Coinsurance**

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible. Coinsurance for medical services counts toward the medical Out-of-Pocket Maximum; however, coinsurance for prescription drugs does not count toward the medical Out-of-Pocket Maximum; there is a separate prescription drug Out-of-Pocket Maximum.

**Out-of-Pocket Maximum**

The medical annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your medical Out-of-Pocket Maximums:

| <b>Plan Features</b>                                                      | <b>Applies to the Medical Out-of-Pocket Annual Maximum?</b> |
|---------------------------------------------------------------------------|-------------------------------------------------------------|
| Copays for medical services or supplies                                   | Yes                                                         |
| Copays for prescription drugs obtained through CVS/caremark               | No                                                          |
| Payments toward any Annual Deductible                                     | Yes                                                         |
| Coinsurance Payments for medical services or supplies                     | Yes                                                         |
| Coinsurance payments for prescription drugs obtained through CVS/caremark | No                                                          |
| Charges for non-Covered Health Services                                   | No                                                          |
| Charges that exceed Eligible Expenses                                     | No                                                          |

## SECTION 2 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

**What this section includes:**

- An overview of the Personal Health Support program; and
- Covered Health Services which Require Prior Authorization.

### Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses focus their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with a direct telephone number so you can call with questions about your condition, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the telephone number on your ID card.

### **Prior Authorization**

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

When you choose to receive certain Covered Health Services from Out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an Out-of-Network provider intends to admit you to an In-Network facility or refers you to other In-Network providers.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process. The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs. Once you have obtained the authorization, please review it carefully so that you understand which services have been authorized and which providers are authorized to deliver the services that are subject to the authorization.

### **Covered Health Services which Require Prior Authorization**

**Please note that prior authorization is required for the below Covered Health Services even if you have a referral from your Primary Physician to seek care from another In-Network Physician.**

In-Network providers are responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you.

The Out-of-Network services that require prior authorization from the Claims Administrator are:

- Ambulance - non-emergent;
- Cellular and Gene Therapy;
- Clinical Trials;
- Congenital Heart Disease services;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria;
- Genetic Testing - BRCA (Breast Cancer);
- Home health care including nutritional foods and Private Duty Nursing;
- Hospice care - inpatient;
- Hospital Inpatient Stay - all scheduled admissions;
- Lab, X-Ray and Diagnostics - Outpatient - Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram;
- Lab, X-Ray and Major Diagnostics - Outpatient - CT, PET scans, MRI, MRA and nuclear medicine including nuclear cardiology;
- Mental Health Services - inpatient services (including services at a Residential Treatment facility). Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment program; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management;
- Morbid obesity surgery;
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including services at a Residential Treatment facility). Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment program; psychological testing; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- Pregnancy - Maternity Services that exceeds the delivery timeframes as described in Section 4, *Additional Coverage Details*;
- Private Duty Nursing - Outpatient;
- Prosthetic Devices for items that will cost more than \$1,000 to purchase or rent;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment as described in Section 4, *Additional Coverage Details* - physical therapy, occupational therapy and speech therapy;

- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Speech therapy for cleft lip and/or cleft palate;
- Substance-Related and Addictive Disorders Services - inpatient services (including services at a Residential Treatment facility). Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment program; psychological testing; extended outpatient treatment visits, with or without medication management;
- Surgery - Outpatient - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization, electrophysiology implant and sleep apnea surgeries as described under Surgery - Outpatient in Section 4, *Additional Coverage Details*;
- Temporomandibular joint services;
- Therapeutic Treatments - IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound;
- Transplantation services;
- Vision Rehabilitation; and
- Vision Therapy.

Notification is required as soon reasonably possible after you are admitted to an Out-of-Network Hospital as a result of an Emergency.

**Contacting the Claims Administrator or Personal Health Support is easy.**  
Simply call the telephone number on your ID card.

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

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

### **Special Note Regarding Medicare**

If you are eligible for Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 8, *Coordination of Benefits (COB)*. You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

## SECTION 3 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

| Plan Features                                                                  | PPO Without Differential |
|--------------------------------------------------------------------------------|--------------------------|
| <b>Copay/Coinsurances<sup>1</sup></b>                                          |                          |
| ■ Emergency Health Services                                                    | \$145                    |
| ■ Hospital - Inpatient Stay and Professional Charges                           | \$365                    |
| ■ Physician's Office Services - Primary Physician                              | \$30                     |
| ■ Physician's Office Services - Specialist                                     | \$60                     |
| ■ Urgent Care Center Services                                                  | \$65                     |
| ■ Virtual Visits                                                               | \$15                     |
| <b>Annual Deductible<sup>2</sup></b>                                           |                          |
| ■ Individual                                                                   | \$125                    |
| ■ Individual plus Spouse                                                       | \$250                    |
| ■ Individual plus Child(ren)                                                   | \$250                    |
| ■ Family (not to exceed \$125 per Covered Person up to a maximum of \$250)     | \$250                    |
| <b>Annual Out-of-Pocket Maximum<sup>2</sup></b>                                |                          |
| ■ Individual                                                                   | \$2,100                  |
| ■ Individual plus Spouse                                                       | \$4,200                  |
| ■ Individual plus Child(ren)                                                   | \$4,200                  |
| ■ Family (not to exceed \$2,100 per Covered Person up to a maximum of \$4,200) | \$4,200                  |

| Plan Features                                                                                                                                                              | PPO Without Differential |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| <b>Lifetime Maximum Benefit</b><br>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. | Unlimited                |

<sup>1</sup>In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

<sup>2</sup>Copays and coinsurance for medical services and supplies do not apply toward the Annual Deductible but do apply to the medical Out-of-Pocket Maximum. Copays and coinsurance for prescription drugs do not apply toward the Annual Deductible or the medical Out-of-Pocket Maximum. There is a separate annual Out-of-Pocket Maximum for prescription drugs obtained through CVS/caremark. See *Prescription Drugs* section for information.

<sup>3</sup>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders 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.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 4, *Additional Coverage Details*.

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                | Benefit<br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acupuncture Services</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> </ul> <p>Your provider must provide a treatment plan that indicates the frequency and duration of your visits for your condition.</p>                                                                                                         | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p>                                                                                             |
| <b>Allergy Injections</b> <ul style="list-style-type: none"> <li>■ Primary Physician or Specialist Physician (Copay is per visit)</li> </ul>                                                                                                                                                                                                                                                                        | <p>100% after you pay a \$10 Copay</p>                                                                                                                                    |
| <b>Ambulance Services</b> <ul style="list-style-type: none"> <li>■ Emergency Ambulance</li> <li>■ Non-Emergency Ambulance (Prior Authorization Required)</li> </ul>                                                                                                                                                                                                                                                 | <p>100%</p> <p>100%</p>                                                                                                                                                   |
| <b>Cellular and Gene Therapy</b> <p>Cellular and Gene Therapy services must be received at a Designated Provider.</p>                                                                                                                                                                                                                                                                                               | <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</p> |
| <b>Chiropractic Care</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> </ul> <p>Spinal Manipulations require a Specialist Physician copay and are limited to 60 visits per calendar year as noted under Section 4, <i>Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment</i>.</p> | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p>                                                                                             |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                      | Benefit<br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Clinical Trials</b>                                                                                                                                                                                                                                                                    | Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.                                                                                                                                                                                                                                                                                                                                  |
| <b>Congenital Heart Disease (CHD) Surgeries</b> <ul style="list-style-type: none"> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> </ul>                                                                                                           | 100% after you pay a \$365 Copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Dental Services - Accident Only</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> </ul> <p>See Section 4, <i>Additional Coverage Details</i> for more information.</p>                     | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p>                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Diabetes Services</b> <p>Diabetes Self-Management and Training/<br/>Diabetic Eye Examinations/Foot Care</p> <ul style="list-style-type: none"> <li>■ Insulin pumps and supplies and blood glucose meters including continuous glucose monitors</li> <li>■ Diabetes supplies</li> </ul> | <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.</p> <p>Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.</p> <p>Benefits for diabetes supplies are covered through Prescription Drug Services through the Pharmacy Benefit Manager.</p> |
| <b>Durable Medical Equipment (DME)</b> <p>You must obtain prior authorization before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (purchase price, cumulative rental, repair or replacement of</p>                                                 | 90% after you meet the Annual Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                              | Benefit<br>(The Amount Payable by the Plan based on Eligible Expenses)                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| a single item.)<br>See Section 4, <i>Additional Coverage Details</i> for more information.                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                    |
| <b>Emergency Health Services - Outpatient</b> <ul style="list-style-type: none"> <li>■ Emergency</li> </ul> <p>If you are admitted as an inpatient to a Hospital directly from the Emergency Room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.</p> <ul style="list-style-type: none"> <li>■ Non-Emergency</li> </ul> <p>See Section 4, <i>Additional Coverage Details</i> for more information.</p> | <p>100% after you pay a \$145 Copay</p> <p>70% after you meet the Annual Deductible</p>                                                                            |
| <b>Enteral Nutrition</b> <ul style="list-style-type: none"> <li>■ Outpatient or Alternate Facility Services</li> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> </ul>                                                                                                                                                                                                                                     | <p>100%</p> <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p>                                                                          |
| <b>Gender Dysphoria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. |
| <b>Home Health Care</b><br>Up to 100 visits per calendar year<br>See Section 4, <i>Additional Coverage Details</i> for more information.                                                                                                                                                                                                                                                                                                                          | 90% after you meet the Annual Deductible                                                                                                                           |
| <b>Hospice Care</b> <ul style="list-style-type: none"> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> </ul>                                                                                                                                                                                                                                                                                                               | 100% after you pay a \$365 Copay                                                                                                                                   |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                          | Benefit<br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>■ Outpatient or Alternate Facility Services</li> </ul> <p>See Section 4, <i>Additional Coverage Details</i> for more information.</p>                                                                                                                                                                                                                                  | 90% after you meet the Annual Deductible                                                                                                                                                    |
| <p><b>Hospital - Inpatient Stay</b><br/>(Copay is per admission)</p>                                                                                                                                                                                                                                                                                                                                          | 100% after you pay a \$365 Copay                                                                                                                                                            |
| <p><b>Infertility Services and Fertility Solutions (FS) Program</b><br/>Infertility services must be received at a Designated Provider.</p> <p>See Section 4, <i>Additional Coverage Details</i>, for limits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.</p> | Depending upon where the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section. |
| <p><b>Lab, X-Ray and Diagnostics - Outpatient</b></p>                                                                                                                                                                                                                                                                                                                                                         | 90% after you meet the Annual Deductible                                                                                                                                                    |
| <p><b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient (Prior Authorization Required)</b></p>                                                                                                                                                                                                                                                                           | 90% after you meet the Annual Deductible                                                                                                                                                    |
| <p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> <li>■ Outpatient Provider's Office Services (Copay is per visit)</li> </ul>                                                                                                                                                                    | <p>100% after you pay a \$365 Copay</p> <p>100% after you pay a \$30 Copay</p> <p>90% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>   |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Benefit<br>(The Amount Payable by the Plan based on Eligible Expenses)                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Morbid Obesity Surgery</b></p> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> <li>■ Outpatient Physician Fees for Surgical and Medical Services</li> <li>■ Inpatient Services rendered at a Designated Provider</li> </ul> <p>See Section 4, <i>Additional Coverage Details</i> for more information.</p> | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>100% after you pay a \$365 Copay</p> <p>90% after you meet the Annual Deductible</p> <p>100% after you pay a \$365 Copay</p> |
| <p><b>Neurobiological Disorders - Autism Spectrum Disorder Services</b></p> <ul style="list-style-type: none"> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> <li>■ Outpatient Provider's Office Services (Copay is per visit)</li> </ul>                                                                                                                                                                                                                 | <p>100% after you pay a \$365 Copay</p> <p>100% after you pay a \$30 Copay</p> <p>90% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible</p>                    |
| <p><b>Nutrition</b></p> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> <li>■ Nutritional Supplies</li> </ul> <p>See Section 4, <i>Additional Coverage Details</i> for more information.</p>                                                                                                                                                                 | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p>                                 |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                 | Benefit<br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Nutritional Counseling</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> </ul> <p>Up to three visits per condition per lifetime.<br/>See Section 4, <i>Additional Coverage Details</i> for covered medical conditions.</p>                                            | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p>                                                                                         |
| <b>Ostomy Supplies</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> </ul>                                                                                                                                                    | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>90% after you meet the Annual Deductible</p>                                         |
| <b>Pharmaceutical Products Administered by a Physician - Outpatient</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> </ul>                                                                                                   | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>90% after you meet the Annual Deductible</p>                                         |
| <b>Physician Fees for Surgical and Medical Services</b> <ul style="list-style-type: none"> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> <li>■ Primary Physician, includes OB/GYN physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> </ul> | <p>100% after you pay a \$365 Copay</p> <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>90% after you meet the Annual Deductible</p> |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Benefit<br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Physician's Office Services - Sickness and Injury</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Allergy Injections (Copay is per visit)</li> </ul>                                                                                                                                                                                                                                                                                                          | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>100% after you pay a \$10 Copay</p>                                                                             |
| <b>Pregnancy - Maternity Services</b> <ul style="list-style-type: none"> <li>■ Physician's Office Services (No Copay applies for prenatal visits after the first visit)</li> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> </ul> <p>A separate Copay will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p> <ul style="list-style-type: none"> <li>■ Outpatient Physician Fees for Surgical and Medical Services</li> <li>■ Sonogram and X-Rays</li> </ul> | <p>100% after you pay a \$30 Primary Physician Copay</p> <p>100% after you pay a \$365 Copay</p> <p>90% after you meet the Annual Deductible</p> <p>90% after you meet the Annual Deductible</p> |
| <b>Preventive Care Services</b> <ul style="list-style-type: none"> <li>■ Physician Office Services.</li> <li>■ Lab, X-ray or Other Preventive Tests (one vision screening and one hearing screening per calendar year limited to Dependent Children only under age 18 as part of a well-child visit).</li> <li>■ Breast Pumps.</li> </ul>                                                                                                                                                                                                                            | <p>100%</p> <p>100%</p> <p>100%</p>                                                                                                                                                              |

| <b>Covered Health Services<sup>1</sup></b>                                                                                                                                                                                                                                                                                                                                                                                | <b>Benefit</b><br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Private Duty Nursing - Outpatient</b><br>Up to 100 visits per calendar year<br>See Section 4, <i>Additional Coverage Details</i> for more information.                                                                                                                                                                                                                                                                 | 90% after you meet the Annual Deductible                                                                                                                                                                                                                       |
| <b>Prosthetic Devices</b><br>See Section 4, <i>Additional Coverage Details</i> , for limits.                                                                                                                                                                                                                                                                                                                              | 90% after you meet the Annual Deductible                                                                                                                                                                                                                       |
| <b>Reconstructive Procedures</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> <li>■ Outpatient Physician Fees for Surgical and Medical Services</li> <li>■ Prosthetic Devices - Outpatient</li> <li>■ Surgery – Outpatient</li> </ul> | 100% after you pay a \$30 Copay<br><br>100% after you pay a \$60 Copay<br><br>100% after you pay a \$365 Copay<br><br>90% after you meet the Annual Deductible<br><br>90% after you meet the Annual Deductible<br><br>90% after you meet the Annual Deductible |
| <b>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</b> <ul style="list-style-type: none"> <li>■ Provider's Office Services (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> </ul> See Section 4, <i>Additional Coverage Details</i> , for visit limits and Chiropractic Care.                                                                                                 | 100% after you pay a \$30 Copay<br><br>90% after you meet the Annual Deductible                                                                                                                                                                                |
| <b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>                                                                                                                                                                                                                                                                                                                                                          | 90% after you meet the Annual Deductible                                                                                                                                                                                                                       |
| <b>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b><br>(Copay is per admission)<br>Up to 60 days per calendar year<br>See Section 4, <i>Additional Coverage Details</i> for                                                                                                                                                                                                                        | 100% after you pay a \$365 Copay                                                                                                                                                                                                                               |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                                                                                          | Benefit<br><i>(The Amount Payable by the Plan based on Eligible Expenses)</i>                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| more information.                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                 |
| <b>Substance-Related and Addictive Disorders Services</b> <ul style="list-style-type: none"> <li>■ Hospital - Inpatient Stay and Professional Charges (Copay is per admission)</li> <li>■ Outpatient Provider's Office Services (Copay is per visit)</li> </ul>                                                                               | <p>100% after you pay a \$365 Copay</p> <p>100% after you pay a \$30 Copay</p> <p>90% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible</p>                      |
| <b>Surgery - Outpatient</b> <ul style="list-style-type: none"> <li>■ Physician's Office Services (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> </ul>                                                                                                              | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>90% after you meet the Annual Deductible</p>                                                                                   |
| <b>Temporomandibular Joint (TMJ) Services</b><br>(Copay is per visit)                                                                                                                                                                                                                                                                         | Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section. |
| <b>Therapeutic Treatments – Outpatient (Prior Authorization Required)</b><br><b>Chemotherapy, Radiation and Kidney Dialysis</b> <ul style="list-style-type: none"> <li>■ Primary Physician (Copay is per visit)</li> <li>■ Specialist Physician (Copay is per visit)</li> <li>■ Hospital - Inpatient Stay and Professional Charges</li> </ul> | <p>100% after you pay a \$30 Copay</p> <p>100% after you pay a \$60 Copay</p> <p>100% after you pay a \$365 Copay</p>                                                                                           |

| Covered Health Services <sup>1</sup>                                                                                                                                                                                                                                    | Benefit<br>( <i>The Amount Payable by the Plan based on Eligible Expenses</i> )                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Transplantation Services</b>                                                                                                                                                                                                                                         | Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section. |
| <b>Urgent Care Center Services</b><br>(Copay is per visit)                                                                                                                                                                                                              | 100% after you pay a \$65 Copay                                                                                                                                                                   |
| <b>Urinary Catheters</b>                                                                                                                                                                                                                                                | 90% after you meet the Annual Deductible                                                                                                                                                          |
| <b>Virtual Visits</b><br>Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <b>www.myuhc.com</b> or by calling the telephone number on your ID card. | 100% after you pay a \$15 Copay                                                                                                                                                                   |
| <b>Vision Therapy and Rehabilitation</b><br><ul style="list-style-type: none"> <li>■ Physician's Office Services (Copay is per visit)</li> <li>■ Outpatient Professional Charges</li> </ul>                                                                             | <p>100% after you pay a \$30 Copay</p> <p>90% after you meet the Annual Deductible</p>                                                                                                            |
| <b>Wigs</b><br>Charges for a Physician's office visit are described under <i>Physician's Office Services - Sickness and Injury</i> in this section.                                                                                                                     | 100%                                                                                                                                                                                              |

<sup>1</sup>Please obtain prior authorization before receiving Covered Health Services, as described in Section 4, *Additional Coverage Details*.

## SECTION 4 - ADDITIONAL COVERAGE DETAILS

### What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from the Claims Administrator or Personal Health Support before you receive them.

This section supplements the second table in Section 3, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance, and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 6, *Exclusions*.

### Acupuncture Services

The Plan pays for acupuncture services when used as a general anesthetic for pain therapy, and or nausea provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- pregnancy; and
- post-operative procedures.

Your provider must provide a treatment plan that indicates the frequency and duration of your visits for your condition.

### Did you know?

You generally pay less out-of-pocket when you use an In-Network provider.

### Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 10, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from an Out-of-Network Hospital to an In-Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

**Prior Authorization Requirement**

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency air ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization as soon as possible before transport.

## Cellular and Gene Therapy

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

Cellular Therapy and Gene Therapy services must be received at a Designated Provider.

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

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Benefits will not be paid.

## Clinical Trials

Benefits are available for 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;

- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

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 include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision 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. The only exceptions to this are:
  - certain *Category B* devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- 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 which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));*
  - *Centers for Disease Control and Prevention (CDC);*
  - *Agency for Healthcare Research and Quality (AHRQ);*
  - *Centers for Medicare and Medicaid Services (CMS);*
  - a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
  - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - *The Department of Veterans Affairs, the Department of Defense or the Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - ◆ 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. We 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.

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises.

## **Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the toll-free number on your ID card for information about these guidelines.

The Plan pays for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **[www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com)**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury;*
- *Physician Fees for Surgical and Medical Services;*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic;*
- *Therapeutic Treatments - Outpatient;*
- *Hospital - Inpatient Stay; and*
- *Surgery - Outpatient.*

To receive Benefits under the CHD program, you must contact the Claims Administrator at (888) 936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

**Prior Authorization Requirements**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises.

**Note:** The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with CHD services received by a Designated Provider.

**Dental Services**

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident and is not considered an accidental injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Coverage will be provided under the medical program only for the following dental services if determined to be medically necessary:

- Repair or replacement of sound natural teeth that have been damaged or lost due to injury or a specific disease process affecting the mouth, cheeks, lips, jaw, or chin (excluding periodontal disease) if:
  - The injury or disease did not arise while, or as a result of, biting or chewing; and
  - Treatment starts within six months of the injury or disease. However, if due to the nature of the injury or disease, treatment could not begin within six months of the injury or disease, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

Coverage is limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury or disease and use of implants if medically necessary to replace the tooth and teeth injured or lost as a direct and sole result of the accidental bodily injury or disease.

- Treatment, including orthodontic treatment, of cleft lip and/or cleft palate as described above.
- Oral surgery limited to:
  - non-dental surgical procedures for congenital defects, such as cleft lip and/or cleft palate;
  - medically necessary diagnostic and surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, procedures to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such injuries occurred while covered under the Medical Program;
  - the reduction of, dislocation of, or excision of temporomandibular joints;
  - procedures involving accessory sinuses, salivary glands or ducts;
  - excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required;

- excision of exostosis of the jaw and hard palate when not related to the fitting of dentures; and
- extraoral incision and drainage of abscesses with cellulitis.

***General Anesthesia for Dental Care***

Benefits for general anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care will be provided to a member under the following circumstances if the member is:

- seven (7) years of age or younger or developmentally disabled;
  - an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition; and
  - an individual for whom a superior result can be expected from dental care provided under general anesthesia; or
- 17 years of age or younger;
  - an extremely uncooperative, fearful or uncommunicative individual;
  - an individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
  - an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth or other increased oral or dental morbidity.

Benefits for general anesthesia and associated Hospital or ambulatory facility charges are restricted to dental care that is provided by:

- a fully accredited specialist in pediatric dentistry;
- a fully accredited specialist in oral and maxillofacial surgery; and
- a dentist to whom hospital privileges have been granted.

The Plan does not provide Benefits for general anesthesia and associated Hospital or ambulatory facility charges for dental care rendered for Temporomandibular Joint Disorders.

The Plan does not cover the extraction of any impacted teeth.

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

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

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

***Diabetic Self-Management Items***

Insulin pumps and supplies and blood glucose meters including continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME).

Diabetic supplies for which Benefits are covered through Prescription Drug Services through the Pharmacy Benefit Manager include insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets, lancets and lancet devices, NovoPen, BD Pen, pen needle, alcohol wipes and injectables other than insulin.

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator before acquiring any Durable Medical Equipment (DME), such as an insulin pump, for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

**Durable Medical Equipment (DME)**

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- continuous positive airway pressure (CPAP) device and supplies;
- equipment to assist mobility, such as a standard wheelchair;
- hospital beds and medical specialty beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;

- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient* in this section;
- shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics when prescribed by a Physician;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;
- externally worn braces which support, align or correct deformities to, or improve the function of, a limb or other moving body part, including soft or rigid gas permeable contact lenses or sclera shells for use in the treatment of a condition other than correction of vision. Corrective braces, casts, and slings are examples of covered corrective appliances;
- custom molded cranial orthotics (helmets) and foot orthotics are covered, when prescribed by Physician;
- equipment for the treatment of chronic or acute respiratory failure or conditions; and
- ostomy supplies.

The Plan also covers tubings, nasal cannulas, connectors, and masks used in connection with DME.

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

**Note:** DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another

item/device. Requests for repairs may be made at any time and are not subject to the three year time frame for replacement.

**Prior Authorization Requirement**

You must obtain prior authorization the Claims Administrator before acquiring any Durable Medical Equipment (DME) that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

**Emergency Health Services - Outpatient**

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Hospital directly from the Emergency Room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Hospital will apply instead.

If you are admitted to a Hospital as a result of an Emergency, you must notify the Claims Administrator as soon as is reasonably possible.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency as shown in the *Covered Health Services* section.

**Prior Authorization Requirement**

Please remember for Out-of-Network Benefits, you must notify the Claims Administrator as soon as reasonably possible if you are admitted to an Out-of-Network Hospital as a result of an Emergency.

**Enteral Nutrition**

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

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

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

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

- Amino acid-based elemental formulas.

- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

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

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

## **Gender Dysphoria**

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in your SPD.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

### *Male to Female:*

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

### *Female to Male:*

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis

- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

**Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:**

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

**Prior Authorization Requirement for Surgical Treatment**

You must obtain prior authorization as soon as the possibility of surgery arises.

**Prior Authorization Requirement for Non-Surgical Treatment**

Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

## Genetic Testing

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

### **Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA (Breast Cancer) is performed.

## Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 10, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 10, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are limited to 100 visits per calendar year. One visit equals four hours of Skilled Care services. Additional visits may be granted based on medical necessity with documentation requirements to qualify for additional visits.

Custodial Care is not covered.

### **Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as is reasonably possible.

## Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual, and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Respite Care will be limited to an annual benefit of 14 days. “Respite Care” means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member.

Custodial Care is not covered.

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as reasonably possible.

**Hospital - Inpatient Stay**

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency Room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

**Prior Authorization Requirement**

For:

- a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission;
- a non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

**Infertility Services**

Therapeutic services for the treatment of Infertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).

- Assisted Reproductive Technologies (ART).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Embryo transportation related network disruption.
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- ICSI - (intracytoplasmic sperm injection).
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty and ovarian cystectomy.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under *Pharmaceutical Products*.

### **Criteria to be eligible for Benefits**

To be eligible for the Infertility services Benefit you must have a diagnosis of infertility.

- To meet the definition of Infertility you must meet one of the following:
  - You are not able to become pregnant after the following periods of time of regular unprotected intercourse or Therapeutic Donor Insemination:
    - ◆ One year, if you are a female under age 35.
    - ◆ Six months, if you are a female age 35 or older.
  - You are female and have failed to achieve or maintain a Pregnancy due to impotence/sexual dysfunction;
  - You are female and have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

- You are male and have a diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- You have infertility that is not related to voluntary sterilization.
- You are a female:
  - under age 44 and using own oocytes (eggs).
  - under age 55 and using donor oocytes (eggs).

**Note:** For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Not a Child Dependent.

Benefits are limited to \$25,000 per Covered Person during the entire period you are covered under the Plan. There are separate medical and prescription drug lifetime maximum Benefits. Your Prescription Drug Services through the Pharmacy Benefit Manager is limited to \$10,000 per Covered Person during the entire period you are covered under your pharmacy plan. Please see the Pharmacy Benefit Manager for details. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.

Only charges for the following apply toward the infertility lifetime maximum:

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

### **Lab, X-Ray and Diagnostics - Outpatient**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- lab and radiology/x-ray;
- sonogram; and
- mammography.

Benefits under this section include:

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

- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, x-ray, and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

#### **Prior Authorization Requirements**

For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.

### **Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient**

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility. Prior authorization is required for Major Diagnostics Benefits.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

#### **Prior Authorization Requirements**

For CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.

### **Mental Health Services**

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

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.

- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator at 1-855-434-2684 for referrals to providers and coordination of care.

#### **Prior Authorization Requirement**

For:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

#### **Morbid Obesity Surgery**

The Plan covers surgical treatment of morbid obesity provided by or under the direction of a Physician provided either of the following is true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by morbid obesity.

In addition to meeting the above criteria, the following must also be true:

- you have documentation from a Physician of a diagnosis of morbid obesity;
- you are over the age of 18 (adolescents are not covered);

- you have completed a 6-month Physician supervised weight loss program within the past two years;
- you have completed a pre-surgical psychological evaluation within the last 12 months; and
- the surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by an In-Network surgeon even if there are no BRS Designated Providers near you.

Benefits are available for morbid obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 10, *Glossary* and are not Experimental or Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

Excess skin removal is not covered, unless medically necessary.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 10, *Glossary*, for morbid obesity surgery services.

For morbid obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling toll-free at (888) 936-7246. If you receive morbid obesity surgery that is not performed as part of the Bariatric Resource Services program, no Plan benefits are available.

**Note:** The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with obesity-related services received by a Designated Provider.

#### **Prior Authorization Requirement**

For Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of morbid obesity surgery arises.

It is important that you provide notification regarding your intention to have morbid obesity surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

### **Neurobiological Disorders - Autism Spectrum Disorder Services**

The Plan pays Benefits for behavioral services for Autism Spectrum Disorders including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.

- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator at 1-855-434-2684 for referrals to providers and coordination of care.

**Prior Authorization Requirement**

For:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

**Nutrition**

The Plan pays Benefits for low protein modified food products for therapeutic treatment, under the direction of a physician, for inherited metabolic diseases. A Low Protein Modified Food Product means a food product that is specially formulated to have less than one (1) gram of protein per serving (excluding a natural food that is naturally low in protein); or is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). The Plan pays Benefits for donor breast milk, provided it is the sole source of nutrition.

The Plan pays Benefits for formula under the direction of a physician when administered through a feeding tube for:

- malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility (including but not limited to Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, inherited diseases of amino and/or organic acids.
- central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.

In addition, the Plan pays Benefits for food thickeners when Medically Necessary to safely ingest oral nutrition.

**Nutritional Counseling**

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Examples of such medical conditions include but are not limited to:

- Congestive heart failure;
- Coronary artery disease;
- Crohn's disease;
- Chronic obstructive pulmonary disease;
- Diabetes mellitus;
- Gout (a form of arthritis);
- Hyperlipidemia (excess of fatty substances in the blood);
- Phenylketonuria (a genetic disorder diagnosed at infancy); and
- Renal failure.

Benefits are limited to three individual sessions in your lifetime for each medical condition. This limit applies to non-preventive nutritional counseling services only.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

### **Ostomy Supplies**

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags, and ostomy irrigation catheters; and
- skin barriers.

### **Pharmaceutical Products - Outpatient**

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such

Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at [www.myuhc.com](http://www.myuhc.com) or by calling the telephone number on your ID card.

### **Physician Fees for Surgical and Medical Services**

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

### **Physician's Office Services - Sickness and Injury**

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness. The Plan also pays Benefits for travel immunizations.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

#### **Please Note**

Your Physician does not have a copy of your Summary Plan Description and is not responsible for knowing or communicating your Benefits.

### **Pregnancy - Maternity Services**

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. This Plan covers a Child Dependent's obstetrical care, including any services incident to or resulting from pregnancy.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

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

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

**Newborn Process:** A newborn who is eligible as a child Dependent is automatically covered for a 31-day period under the associate's Social Security Number as "Baby Boy or Baby Girl." Claims incurred/submitted during this period of time will be paid. Any claims received more than 31-days after the child's birth or adoption will be denied unless the child has already been added as a Dependent through the Employer's enrollment process. This Plan does not provide coverage for the newborn child of the Dependent. For example, a grandchild, who is not otherwise covered as a Dependent, will not receive coverage.

**Note:** No Copayment applies to Physician office visits for prenatal care after the first visit.

#### **Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

#### **Healthy Moms and Babies**

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 5, *Clinical Programs and Resources*, for details.

### **Preventive Care Services**

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*;
- immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*;

- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*, and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 3, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

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

- Which pump is the least expensive;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

In addition to the services listed above, this preventive care benefit includes:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing;
- tests to support cardiovascular health; and
- prostate exam after age 50.

The Plan pays Benefits for Digital Breast Tomosynthesis (DBT) for breast cancer screening and diagnostic testing. DBT is also called a 3-D mammogram.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis.

For questions about your preventive care Benefits under this Plan, call the telephone number on your ID card.

### **Private Duty Nursing - Outpatient**

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

For Private Duty Nursing to be covered it must be provided by a contracted home health care provider. There must be a treatment plan in place by the physician for care.

Benefits are limited to 100 visits per calendar year. One visit equals eight hours of Private Duty Nursing services. Additional visits may be allowed based on medical information.

UnitedHealthcare does not contract with individual nurses.

Custodial Care is not covered.

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator before scheduled services are received.

**Prosthetic Devices**

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits are provided for members that are aphakic due to intraocular surgery or as a result of an accidental injury. The Plan will cover one (1) pair of eyeglasses or contact lenses used to replace the natural lens and subsequent changes required due to changes in the Member's prescription.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when

the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

**Note:** Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator before acquiring prosthetic devices that exceed \$1,000 in cost per device.

**Reconstructive Procedures**

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly and the primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 10, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

**Prior Authorization Requirement**

For:

- a scheduled admission or procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed;
- a non-scheduled admission or procedure (or inpatient admission resulting from an Emergency) you must provide notification within one business day or as soon as is reasonably possible.

**Rehabilitation Services and Habilitative - Outpatient Therapy and Manipulative Treatment**

The Plan provides short-term outpatient rehabilitation services (including habilitative services) for the following types of therapy:

- physical therapy;
- occupational therapy;
- manipulative treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

The Plan gives UnitedHealthcare the right to exclude from coverage rehabilitation services that are not expected to result in significant physical improvement in your condition within two months of the start of treatment. In addition, UnitedHealthcare has the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

### ***Habilitative Services***

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

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

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency,

anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

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

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

Benefits are limited to:

- 90 visits per calendar year for physical, occupational and speech therapy combined; and
- 60 visits per calendar year for Manipulative Treatment.

Additional visits beyond the annual limit for manipulative treatments, physical, occupational and speech therapy are only covered if determined to be Medically Necessary.

No visit limitation applies to pulmonary rehabilitation therapy, cardiac rehabilitation therapy, and post-cochlear implant aural therapy.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

**Prior Authorization Requirement**

You must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as is reasonably possible.

In addition, you must obtain prior authorization for speech therapy for cleft lip and/or cleft palate.

**Scopic Procedures - Outpatient Diagnostic and Therapeutic**

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists, and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

### **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

**Note:** The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 10, *Glossary*.

Benefits are limited to 60 days per calendar year. Additional visits beyond the annual limit are only covered if determined to be medically necessary.

Custodial Care is not covered.

#### **Prior Authorization Requirement**

For:

- a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission;
- a non-elective admissions (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

### **Substance-Related and Addictive Disorders Services**

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

Benefits include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator at 1-855-434-2684 for referrals to providers and coordination of care.

#### **Prior Authorization Requirement**

For:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management.

#### **Surgery - Outpatient**

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy); and
- physician services for radiologists, anesthesiologists, and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

**Prior Authorization Requirement**

For cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization, electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

**Temporomandibular Joint (TMJ) Services**

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint (TMJ) when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs, and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, and open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

**Prior Authorization Requirement**

You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital.

**Therapeutic Treatments - Outpatient**

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy, and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.

**Prior Authorization Requirement**

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

**Transplantation Services**

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures including CAR-T cell therapy for malignancies must be ordered by an In-Network provider and received at a Designated Provider. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow including CAR-T cell therapy for malignancies (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator or Personal Health Support for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

**Prior Authorization Requirement**

You must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, Benefits will not be paid.

**Support in the event of serious illness**

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

**Urgent Care Center Services**

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 10, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

**Urinary Catheters**

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

**Virtual Visits**

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

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com](http://www.myuhc.com) or by calling the telephone number on your ID card.

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

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

### **Vision Examinations**

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office or outpatient facility (vision screenings do not include refractive examinations to detect vision impairment).

### **Vision Rehabilitation**

Vision rehabilitation services will be covered for members with a diagnosis of moderate or severe vision impairment including blindness that is not correctable by conventional methods, such as glasses or surgery. Rehabilitation may be conducted under general supervision of a qualified physician or optometrist, in appropriate settings including in the home of the beneficiary receiving the services. Rehabilitation must be prescribed by a qualified physician and administered under an individualized, written plan of care developed by a qualified physician or qualified occupational therapist in private practice (OTPP). The plan of care must contain a specific diagnosis of visual impairment and must assure that vision rehabilitation services are medically necessary and the beneficiary receiving vision rehabilitation is capable of deriving benefit from the rehabilitation. Services will be covered when provided by a qualified occupational therapist, or by a low vision therapist, orientation and mobility specialist, or vision rehabilitation therapists (aka rehabilitation teachers) who is certified by the Academy for Certification of Vision Rehabilitation Professionals (ACVREP).

Rehabilitation will be completed when the treatment goals have been attained or maximum progress toward them has been reached. Any subsequent services would be for maintenance of a level of functional ability (maintenance services are not covered). All services are covered on an individual basis. Group services are not covered.

#### **Prior Authorization Requirement**

You must obtain prior authorization five business days before receiving vision rehabilitation or as soon as is reasonably possible.

## Vision Therapy

Visual therapy services are rendered by an optometrist to correct convergence insufficiency, amblyopia (lazy eye), and eye muscle imbalances resulting in a diagnosis of diplopia, heterotopia or esotropia, are eligible for coverage. Eligible charges for optometric services include:

- therapy directed at restoring eye muscle tone and movement after surgery; and
- therapy for faulty optical fusion to correct muscle imbalances.

No visit limitation applies to vision therapy.

### **Prior Authorization Requirement**

You must obtain prior authorization five business days before receiving vision therapy or as soon as is reasonably possible.

## Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from chemotherapy or radiation therapy for cancer treatment.

## SECTION 5 - CLINICAL PROGRAMS AND RESOURCES

### What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease Management Services;
- Complex Medical Conditions Programs and Services; and
- Women's Health/Reproductive.

GEICO Corporation believes in giving you the tools you need to be an educated health care consumer. To that end, GEICO Corporation has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

### **NOTE:**

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and GEICO Corporation are not responsible for the results of your decisions from the use of the information, including but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

## Consumer Solutions and Self-Service Tools

### *Health Survey*

You are invited to learn more about your health and wellness at [www.myuhc.com](http://www.myuhc.com) and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way. To find the health survey, log on to [www.myuhc.com](http://www.myuhc.com). Next, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the telephone number on your ID card.

### *Reminder Programs*

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;

- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

### ***Decision Support***

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the telephone number on your ID card.

### ***www.myuhc.com***

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for In-Network providers available in your Plan through the online provider directory;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

**Registering on www.myuhc.com**

If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

**Want to learn more about a condition or treatment?**

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

## **Complex Medical Conditions Programs and Services**

### ***Bariatric Resource Services (BRS)***

Your Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

### ***Cancer Resource Services (CRS) Program***

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit **[www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com)** or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

### ***Cancer Support Program***

UnitedHealthcare provides a program that identifies and supports a Covered Person who has cancer. You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies and treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on your ID card or call the program directly at 1-866 936-6002.

### ***Congenital Heart Disease (CHD) Resource Services***

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **[www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com)** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

### ***Kidney Disease Programs***

#### ***Comprehensive Kidney Solution (CKS) program***

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a “best practices” approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **[www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com)** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

#### ***Kidney Resource Services (KRS) program End-Stage Renal Disease (ESRD)***

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you’ll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it’s available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

### ***Transplant Resource Services (TRS) Program***

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **[www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com)** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

### ***Travel and Lodging Assistance Program***

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

### ***Travel and Lodging Expenses***

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of \$10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

### ***Lodging***

- A per diem rate, up to \$50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem, up to \$100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

### ***Transportation***

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

## **Women's Health/Reproductive**

### ***Fertility Solutions program***

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

- Specialized clinical consulting services to Employees and Enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

The Plan pays Benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

### ***Maternity Support Program***

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an obstetrics nurse who is assigned to you.

This program offers:

- Enrollment by an obstetrics nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

***Neonatal Resource Services (NRS) program***

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

## SECTION 6 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

### What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 4, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 4, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 3, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 3, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

### Alternative Treatments

- acupressure;
- aromatherapy;
- hypnotism;
- massage therapy;
- rolfing (holistic tissue massage); and
- art therapy, music therapy, dance therapy, horseback therapy, dolphin therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 4, *Additional Coverage Details*.

### Dental

- dental care, except as identified under *Dental Services* in Section 4, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication or tooth extraction as a result of disease state, such as Sjorgren's Syndrome.

Endodontics, periodontal surgery, and restorative treatment are excluded.

- diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:
  - extractions of any impacted teeth (including wisdom teeth);
  - restoration and replacement of teeth;
  - medical or surgical treatments of dental conditions; and
  - services to improve dental clinical outcomes;

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services* in Section 4, *Additional Coverage Details*.

- dental implants, bone grafts, and other implant-related procedures, including if the procedure resulted from a disease state, such as Sjorgren's Syndrome;
- This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services* in Section 4, *Additional Coverage Details*.
- dental braces (orthodontics);
- dental X-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia; and

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 4, *Additional Coverage Details*.

- treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

### **Devices, Appliances and Prosthetics**

- devices used specifically as safety items or to affect performance in sports-related activities;
- orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 4, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

- the following items are excluded, even if prescribed by a Physician:
  - blood pressure cuff/monitor;
  - enuresis alarm;
  - non-wearable external defibrillator;
  - trusses;
  - ultrasonic nebulizers;
- repairs to prosthetic devices due to misuse, malicious damage or gross neglect;
- replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items;
- devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 4, *Additional Coverage Details*;
- oral appliances for snoring.

**Drugs (See Prescription Drug Services for additional information)**

- prescription drugs for outpatient use that are filled by a prescription order or refill;
- self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), 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 Covered Persons for self-infusion;
- growth hormone therapy;
- non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office;
- over the counter drugs and treatments;
- certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 4, *Additional Coverage Details*;

- a Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;

- a Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;
- benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
- a Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year;
- certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year; and
- compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

### **Experimental or Investigational or Unproven Services**

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

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 4, *Additional Coverage Details*.

### **Foot Care**

- routine foot care. Examples include the cutting or removal of corns and calluses.

This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 4, *Additional Coverage Details*.

- nail trimming, cutting, or debriding (removal of dead skin or underlying tissue);
- hygienic and preventive maintenance foot care. Examples include:
  - cleaning and soaking the feet; and
  - applying skin creams in order to maintain skin tone.

- treatment of flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet or partial removal of a nail without the removal of its matrix;
- treatment of subluxation of the foot; and
- corrective shoes (unless required to be attached to a leg brace).

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

## **Gender Dysphoria**

Cosmetic Procedures, including the following:

- abdominoplasty;
- blepharoplasty;
- breast enlargement, including augmentation mammoplasty and breast implants;
- body contouring, such as lipoplasty;
- brow lift;
- calf implants;
- cheek, chin, and nose implants;
- injection of fillers or neurotoxins;
- face lift, forehead lift, or neck tightening;
- facial bone remodeling for facial feminizations;
- hair removal;
- hair transplantation;
- lip augmentation;
- lip reduction;
- liposuction;
- mastopexy;
- pectoral implants for chest masculinization;
- rhinoplasty;
- skin resurfacing;
- thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple);
- voice modification surgery; and
- voice lessons and voice therapy.

## Hospice

- services, visits, medical equipment or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member;
- financial and legal counseling;
- any service for which a qualified hospice care program does not customarily charge the patient or the Member's family;
- reimbursement for volunteer services;
- chemotherapy or radiation therapy, unless used for symptom control; and
- funeral services.

## Medical Supplies and Equipment

- prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
  - compression stockings;
  - ace bandages;
  - diabetic strips; and
  - syringes.

This exclusion does not apply to:

- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 4, *Additional Coverage Details*;
  - diabetic supplies for which Benefits are covered through Prescription Drug Services;
  - ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 4, *Additional Coverage Details*;
  - oxygen;
  - dressings required in connection with a covered injury, surgical procedure or condition; or
  - urinary catheters for which Benefits are provided as described under *Urinary Catheters* in Section 4, *Additional Coverage Details*.
- tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in Section 4, *Additional Coverage Details*.

## Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 6, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 4, *Additional Coverage Details*.

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

## Nutrition

- nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
- nutritional counseling for either individuals or groups, except as identified under Diabetes Services, and except as defined under *Nutritional Counseling* in Section 4, *Additional Coverage Details*;
- food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 4, *Additional Coverage Details*; and
- health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

**Personal Care, Comfort or Convenience**

- television;
- telephone;
- beauty/barber service;
- guest service;
- supplies, equipment and similar incidentals for personal comfort. Examples include:
  - air conditioners;
  - air purifiers and filters;
  - batteries and battery chargers;
  - dehumidifiers and humidifiers;
  - ergonomically correct chairs;
  - comfort beds, motorized beds and mattresses;
  - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
  - car seats;
  - chairs, feeding chairs, toddler chairs, chair lifts, and recliners;
  - exercise equipment and treadmills;
  - hot tubs, Jacuzzis, saunas, and whirlpools;
  - medical alert systems;
  - music devices;
  - personal computers;
  - pillows;
  - power-operated vehicles;
  - radios;
  - strollers;
  - safety equipment;
  - vehicle modifications such as van lifts;
  - video players; and
  - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

**Physical Appearance**

- cosmetic procedures, as defined in Section 10, *Glossary*, are excluded from coverage. Examples include:
  - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
  - pharmacological regimens;
  - nutritional procedures or treatments;
  - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures);
  - hair removal or replacement by any means;

- treatments for skin wrinkles or any treatment to improve the appearance of the skin;
  - treatment for spider veins;
  - sclerotherapy treatment of veins;
  - skin abrasion procedures performed as a treatment for acne;
  - treatments for hair loss;
  - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
  - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
- physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;
  - weight loss programs whether or not the member is under medical supervision or for medical reasons, even if for morbid obesity;
  - wigs, regardless of the reason for the hair loss, except for chemotherapy or radiation therapy for cancer treatment; and
  - treatment of benign gynecomastia (abnormal breast enlargement in males).

## Procedures and Treatments

- biofeedback;
- medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
- rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;
- speech therapy to treat stuttering, stammering, or other articulation disorders;
- speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 4, *Additional Coverage Details*;
- a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
- excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);
- psychosurgery (lobotomy);

- stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques, and medications to control cravings;
- chelation therapy, except to treat heavy metal poisoning;
- manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain, and improve function, such as asthma or allergies;
- physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
- the following treatments for obesity:
  - non-surgical treatment, even if for morbid obesity; and
  - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Morbid Obesity Surgery* in Section 4, *Additional Coverage Details*;
- medical and surgical treatment of hyperhidrosis (excessive sweating);
- the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment, and dental restorations;
- breast reduction surgery that is determined to be a Cosmetic Procedure;
 

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 4, *Additional Coverage Details*.
- infertility services that are not received at a Designated Provider;
- habilitative services for maintenance/preventive treatment; and
- intracellular micronutrient testing.

## Providers

### Services:

- performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
- a provider may perform on himself or herself;
- performed by a provider with your same legal residence;
- ordered or delivered by a Christian Science practitioner;

- performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
- provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
- which are self-directed to a free-standing or Hospital-based diagnostic facility; and
- ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
  - prior to ordering the service; or
  - after the service is received.

This exclusion does not apply to mammography testing.

## Reproduction

The following treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
  - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
  - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
  - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
  - Ovulation predictor kits.
- The following services related to Gestational Carrier or Surrogate:
    - Fees for the use of a Gestational Carrier or Surrogate.
    - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
    - IVF for a Surrogate.
    - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
- Cost of donor eggs and donor sperm.
  - The reversal of voluntary sterilization.
  - Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
  - Health care services and related expenses for surgical, non-surgical or drug induced Pregnancy termination, unless the life of the mother is endangered or if medical complications arise from an abortion. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

- Emergency contraceptives.
- Infertility services not received from a Designated Provider.
- In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
- Infertility treatment following unsuccessful reversal of voluntary sterilization.
- Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

### Services Provided under Another Plan

Services for which coverage is available:

- under another plan, except for Eligible Expenses payable as described in Section 8, *Coordination of Benefits (COB)*;
- under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you. If benefits subject to this provision are paid or provided by GEICO Corporation, GEICO Corporation reserves all rights to recover the reasonable value of such benefits as described in Section 9, *Subrogation and Right of Reimbursement*.
- while on active military duty; and
- for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably accessible.

### Transplants

- health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 4, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
- health services for transplants involving animal organs;
- transplants that are not performed at a Designated Provider (this exclusion does not apply to cornea transplants); and
- donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

### Travel

- health services provided in a foreign country, unless required as Emergency Health Services;
- Foreign Ambulance Coverage: Applies only if Member is traveling outside the U.S.; and

- travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in Section 5, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 4, *Additional Coverage Details*.

### Types of Care

- custodial care as defined in Section 10, *Glossary* or maintenance care;
- domiciliary care, as defined in Section 10, *Glossary*;
- multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
- private duty nursing received on an inpatient basis;
- respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 4, *Additional Coverage Details*;
- rest cures;
- services of personal care attendants;
- work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

### Vision and Hearing

- implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
- purchase cost and associated fitting charges for eyeglasses or contact lenses, except when used as a prosthetic lens replacement for aphakic patients as described under *Prosthetic Devices* in Section 4, *Additional Coverage Details*;
- purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA), and all other hearing assistive devices;
- surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

### All Other Exclusions

- autopsies and other coroner services and transportation services for a corpse;
- charges for:
  - missed appointments;
  - after-hour appointment surcharges;
  - room or facility reservations;
  - completion of claim forms; or

- record processing.
- charges prohibited by federal anti-kickback or self-referral statutes;
- diagnostic tests that are:
  - delivered in other than a Physician's office or health care facility; and
  - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
- expenses for health services and supplies:
  - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
  - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
  - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
  - that exceed Eligible Expenses or any specified limitation in this Summary Plan Description;
  - for which an Out-of-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;
- foreign language and sign language services;
- long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood, and blood products;
- health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 10, *Glossary*. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:
  - Medically Necessary;
  - described as a Covered Health Service in this Summary Plan Description; and
  - not otherwise excluded in this Summary Plan Description under this Section 6, *Exclusions*.
- health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a

"complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

- physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
  - required solely for purposes of education, sports, camp, career or employment, insurance, marriage or adoption; or as a result of incarceration;
  - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 4, *Additional Coverage Details*;
  - related to judicial or administrative proceedings or orders; or
  - required to obtain or maintain a license of any type.

## SECTION 7 - CLAIMS PROCEDURES

**What this section includes:**

- How In-Network and Out-of-Network claims work; and
- What to do if your claim is denied, in whole or in part.

### In-Network Benefits

In general, if you receive Covered Health Services from an In-Network provider, UnitedHealthcare will pay the Physician or facility directly. If an In-Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the telephone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to an In-Network provider at the time of service, or when you receive a bill from the provider.

### Out-of-Network Benefits

If you receive a bill for Covered Health Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

### If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting [www.myuhc.com](http://www.myuhc.com), calling the telephone number on your ID card or contacting your local Human Resources department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Associate;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and

- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to an Out-of-Network provider without UnitedHealthcare's consent.

### ***Payment of Benefits***

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an Out-of-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to an Out-of-Network provider with UnitedHealthcare's consent, and the Out-of-Network provider submits a claim for payment, you and the Out-of-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the Out-of-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the Out-of-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the Out-of-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to an Out-of-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to an Out-of-Network provider, you remain the sole beneficiary of the payment, and the Out-of-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the Out-of-Network provider as well. If payment to an Out-of-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in Section 8, *Coordination of Benefits*.

### ***Form of Payment of Benefits***

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the

forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

## Health Statements

Each month, in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at [www.myuhc.com](http://www.myuhc.com). You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

## Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the telephone number on your ID card to request them. You can also view and print all of your EOBs online at [www.myuhc.com](http://www.myuhc.com). See Section 10, *Glossary* for the definition of Explanation of Benefits.

### **Important - Timely Filing of Out-of-Network Claims**

All claim forms for Out-of-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

## Claim Denials and Appeals

### *If Your Claim is Denied*

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the telephone number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

### *How to Appeal a Denied Claim*

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;

- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals  
P.O. Box 30432  
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the telephone number on your ID card to request an appeal.

**Types of claims**

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

***Urgent Appeals that Require Immediate Action***

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

***Review of an Appeal***

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

### ***Filing a Second Appeal***

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

### **Federal External Review Program**

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

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

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address noted in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the telephone number on your ID card or by sending a written request to the address noted in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's second decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

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

- a standard external review; and
- an expedited external review.

### ***Standard External Review***

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

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

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for an external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

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

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review

request and UnitedHealthcare will include it with the documents forwarded to the IRO.

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

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

### ***Expedited External Review***

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

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

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

### ***Timing of Appeals Determinations***

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

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 10, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

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

| <b>Urgent Care Request for Benefits*</b>                                             |                 |
|--------------------------------------------------------------------------------------|-----------------|
| <b>Type of Request for Benefits or Appeal</b>                                        | <b>Timing</b>   |
| If your request for Benefits is incomplete, UnitedHealthcare must notify you within: | <b>24 hours</b> |

| <b>Urgent Care Request for Benefits*</b>                                                                              |                                                                            |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Type of Request for Benefits or Appeal</b>                                                                         | <b>Timing</b>                                                              |
| You must then provide completed request for Benefits to UnitedHealthcare within:                                      | <b>48 hours</b> after receiving notice of additional information required  |
| UnitedHealthcare must notify you of the benefit determination within:                                                 | <b>72 hours</b>                                                            |
| If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than: | <b>180 calendar days</b> after receiving the adverse benefit determination |
| UnitedHealthcare must notify you of the appeal decision within:                                                       | <b>72 hours</b> after receiving the appeal                                 |

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

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

| <b>Pre-Service Request for Benefits*</b>                                     |                                                                         |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <b>Type of Request for Benefits or Appeal</b>                                | <b>Timing</b>                                                           |
| You must appeal the first level appeal (file a second level appeal) within:  | <b>60 calendar days</b> after receiving the first level appeal decision |
| UnitedHealthcare must notify you of the second level appeal decision within: | <b>15 calendar days</b> after receiving the second level appeal         |

\*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

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

***Concurrent Care Claims***

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

**Limitation of Action**

See section from the Medical, Dental and Vision Care Plan 12.7 Legal Actions. If a Member has exhausted all available internal appeal rights described in Section 6, the Member may file a lawsuit in state or federal court to recover Benefits. Any lawsuit by a Member against a Claims Administrator, the Medical Program, the Dental Program, the Plan Administrator, the Plan, the Plan Sponsor, or the Group must be commenced within one (1) year from the date the Member received a final Appeal Decision from a Claims Administrator or, if applicable, a final External Review decision from an Independent Review Organization.

## SECTION 8 - COORDINATION OF BENEFITS (COB)

### What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

### Don't forget to update your Dependents' Coordination of Benefits for Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to [www.myuhc.com](http://www.myuhc.com) or call the telephone number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

## Determining Which Plan is Primary

### *Order of Benefit Determination Rules*

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;

- a plan that covers a person as an associate pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;
- plans for active associates pay before plans covering laid-off or retired associates;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

**Determining Primary and Secondary Plan – Examples**

- 1) Let us say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Associate under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let us say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

## **When This Plan is Secondary**

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- if this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

### ***Determining the Allowable Expense If This Plan is Secondary***

#### **What is an allowable expense?**

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

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

## **When a Covered Person Qualifies for Medicare**

### ***Determining Which Plan is Primary***

This Plan shall be considered primary to Medicare for the payment of any services, treatments, or supplies with respect to the following Members who are entitled to Medicare coverage:

- for Medicare entitlement due to age, active Employees who are Members and their covered spouses;
- for Medicare entitlement due to disability, Employees who are Members with coverage due to current employment status and their family members; and
- for Medicare entitlement due to end-stage renal disease, all Members during the first 30 months of such Medicare eligibility or entitlement.

In the event Medicare is the primary payer, the Benefits payable under this Plan shall be reduced by the amount payable under Medicare, if any, regardless of whether the Member has enrolled in Medicare.

For all other Members entitled to Medicare, this Plan shall be considered the secondary plan. The foregoing provisions are intended to comply with the Medicare secondary payer rules.

***Determining the Allowable Expense When This Plan is Secondary to Medicare***

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare in its sole discretion will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

**Medicare Crossover Program**

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the Explanation of Medicare Benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

### **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. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

### **Overpayment and Underpayment of Benefits**

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

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

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

#### ***Refund of Overpayments***

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

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

## SECTION 9 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to “you” or “your” in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

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

### ***Subrogation – Example***

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

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

### ***Reimbursement – Example***

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor in a workers' compensation case or other matter alleging liability;
- any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;

- any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party; and
- 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 its 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 which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - 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 Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including, but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds 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, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and

no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall 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 a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

## Right of Recovery

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

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

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

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

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

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

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

## SECTION 10 - GLOSSARY

**What this section includes:**

- Definitions of terms used throughout this Summary Plan Description (SPD).

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

**Addendum** – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

- surgical services;
- emergency health services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example, a Residential Treatment facility).

**Amendment** – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

**Annual Deductible (or Deductible)** – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 3, *Plan Highlights*.

**Annual Enrollment** – the period of time, determined by GEICO Corporation, during which eligible Associates may enroll themselves and their Dependents under the Plan. GEICO Corporation determines the period of time that is the Annual Enrollment period.

**Assisted Reproductive Technology (ART)** – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).

- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

**Associate** – a full-time or part-time Associate of the Employer who meets the eligibility requirements specified in the Plan. An Associate must live and/or work in the United States.

**Autism Spectrum Disorders** – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

**Bariatric Resource Services (BRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by GEICO Corporation. The BRS program provides:

- specialized clinical consulting services to Associates and enrolled Dependents to educate on morbid obesity treatment options; and
- access to specialized In-Network facilities and Physicians for morbid obesity surgery services.

**Benefits** – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

**BMI** – see Body Mass Index (BMI).

**Body Mass Index (BMI)** – a calculation used in morbid obesity risk assessment which uses a person's weight and height to approximate body fat.

**Cancer Support Program (CSP)** – a program administered by UnitedHealthcare or its affiliates made available to you by GEICO Corporation. The CSP program provides:

- Specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

**Cellular Therapy** - administration of living whole cells into a patient for the treatment of disease.

**CHD** – see Congenital Heart Disease (CHD).

**Claims Administrator** – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

**Clinical Trial** – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

**COBRA** – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

**Coinsurance** – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 1, *How the Plan Works*.

**Company** – GEICO Corporation.

**Congenital Anomaly** – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

**Congenital Heart Disease (CHD)** – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** – a federal law that requires employers to offer continued health insurance coverage to certain associates and their dependents whose group health insurance has been terminated.

**Copayment (or Copay)** – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 1, *How the Plan Works*.

**Cosmetic Procedures** – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

**Cost-Effective** – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

**Covered Health Services** – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms;
- medically necessary;
- included in Sections 3 and 4, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements; and
- not identified in Section 6, *Exclusions*.

**Covered Person** – either the Associate or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**CSP** – see Cancer Support Program (CSP).

**Custodial Care** – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring, and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 3, *Plan Highlights*.

**Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

**Dependent** – an individual who meets the eligibility requirements specified in the Plan. A Dependent does not include anyone who is also enrolled as an Associate. No one can be a Dependent of more than one Associate.

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **[www.myuhc.com](http://www.myuhc.com)** or the telephone number on your ID card.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

**DME** – see Durable Medical Equipment (DME).

**Durable Medical Equipment (DME)** – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or his/her symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

**Eligible Expenses** – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 1, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare’s reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

**Emergency** – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

**Emergency Health Services** – with respect to an Emergency, both of the following:

- A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital.

**Employee Retirement Income Security Act of 1974 (ERISA)** – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers.

**Employer** – GEICO Corporation.

**EOB** – see Explanation of Benefits (EOB).

**ERISA** – see Employee Retirement Income Security Act of 1974 (ERISA).

**Experimental or Investigational Services** – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in Section 4, *Additional Coverage Details*.
- If you are not a participant in a qualifying *Clinical Trial* as described under Section 4, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Explanation of Benefits (EOB)** – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- deductibles;

- coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

**Fertility Solutions (FS)** – a program administered by UnitedHealthcare or its affiliates made available to you by GEICO Corporation. The FS program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

**Gender Dysphoria** - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - ◆ A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - ◆ A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - ◆ A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - ◆ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - ◆ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - ◆ A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

■ *Diagnostic criteria for children:*

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - ◆ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - ◆ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - ◆ A strong preference for cross-gender roles in make-believe play or fantasy play.
  - ◆ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - ◆ A strong preference for playmates of the other gender.
  - ◆ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - ◆ A strong dislike of one's sexual anatomy.
  - ◆ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

**Gene Therapy** - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

**Genetic Counseling - counseling by a qualified clinician that includes:**

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

**Genetic Testing** - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

**Gestational Carrier** - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

**Health Statement(s)** – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

**Home Health Agency** – a program or organization authorized by law to provide health care services in the home.

**Hospital** – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

**Infertility** - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

**Injury** – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**In-Network** – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network provider for only some products. In this case, the provider will be an In-Network provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**In-Network Benefits** - description of how Benefits are paid for Covered Health Services provided by In-Network providers. Refer to Section 3, *Plan Highlights* for details about how In-Network Benefits apply.

**Inpatient Rehabilitation Facility** – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intensive Behavioral Therapy (IBT)** – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

**Intensive Outpatient Treatment** – a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Kidney Resource Services (KRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by GEICO Corporation. The KRS program provides:

- Specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

**Low Protein Modified Food Product** – a food product that is specially formulated to have less than one (1) gram of protein per serving (excluding a natural food that is naturally low in protein).

**Manipulative Treatment** – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medicaid** – a federal program administered and operated individually by participating state and territorial governments that provide medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

**Medically Necessary** – healthcare services that are all of the following as determined by the Claims Administrator or its designee, within Claims Administrator's sole discretion. The services must be:

- in accordance with *Generally Accepted Standards of Medical Practice*;
- clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by The Claims Administrator and revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling the telephone number on your ID card, and to Physicians and other health care professionals on [www.UHCprovider.com](http://www.UHCprovider.com).

**Medicare** – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Health Services** – services for the diagnosis and treatment of those mental health or psychiatric categories that are 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*. The fact that a condition is listed in the current edition of the

*International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance-Related and Addictive Disorders Services Administrator** – the organization or individual who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

**Mental Illness** – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Neonatal Resource Services (NRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by GEICO Corporation. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

**New Pharmaceutical Product** - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

**Out-of-Network Benefits** – description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to Section 3, *Plan Highlights* for details about how Out-of-Network Benefits apply.

**Out-of-Pocket Maximum** – the maximum amount you pay every calendar year. Refer to Section 3, *Plan Highlights* for the Annual Out-of-Pocket Maximum amount. See Section 1, *How the Plan Works* for a description of how the Annual Out-of-Pocket Maximum works.

**Partial Hospitalization/Day Treatment** – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Personal Health Support** – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

**Personal Health Support Nurse** – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

**Pharmaceutical Product(s)** – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

**Physician** – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

**Plan** – The GEICO Corporation Medical, Dental and Vision Care Plan.

**Plan Administrator** – The Benefits Administrative Committee appointed by the Plan Sponsor.

**Plan Sponsor** – GEICO Corporation.

**Pregnancy** – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

**Presumptive Drug Test** - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

**Primary Physician** – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Private Duty Nursing** – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- services exceed the scope of Intermittent Care in the home;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

**Qualified Emergency** – An “emergency” is the treatment of a life-threatening or very serious condition that requires immediate medical treatment. Visits for Out-of-Network emergencies will be paid In-Network if a visit is determined by UHC to be a “Qualified Emergency” (e.g., a patient experiences chest pain and goes to the nearest emergency room that happens to be Out-of-Network. This would be paid as In-Network.).

**Reconstructive Procedure** – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly and the primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Residential Treatment** – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- it is established and operated in accordance with applicable state law for Residential Treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

**Retiree** – an Associate of an Employer who terminates employment prior to age 65 and, as of his termination date, is eligible for early retirement benefits under the early retirement provisions of the Pension Plan.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Shared Savings Program** - a program in which UnitedHealthcare may obtain a discount to an Out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the Out-of-Network provider and a third party vendor. When this applies, the non-Network provider's billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the Out-of-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

In this case the Out-of-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

**Sickness** – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

**Skilled Care** – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

**Skilled Nursing Facility** – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

**Specialist Physician** - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Spouse** – An associate's "legal spouse" is the person, regardless of gender, who is legally married to the associate by a valid marriage certificate issued by any state or country. An associate's former spouse due to divorce or annulment is not an eligible dependent.

**Substance-Related and Addictive Disorders Services** - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a

disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Summary Plan Description (SPD)** - describes the health Benefits available to you and your covered family members under the GEICO Corporation Medical, Dental and Vision Care Plan. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

**Surrogate** - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is, biologically (genetically) related to the child.

**Therapeutic Donor Insemination (TDI)** - Insemination with a donor sperm sample for the purpose of conceiving a child.

**Transitional Living** – Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment, and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Services** – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

**Urgent Care** – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

**Urgent Care Center** – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

## SECTION 11 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

**What this section includes:**

- Plan administrative information, including your rights under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA is the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions (SPDs) by ERISA as defined in Section 10, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

***Plan Sponsor and Administrator***

GEICO Corporation is the Plan Sponsor and has appointed the Benefits Administrative Committee as the Plan Administrator. The Benefits Administrative Committee has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Benefits Administrative Committee  
c/o GEICO Corporation  
One GEICO Plaza  
Washington, DC 20076  
(301) 718-5980

***Claims Administrator***

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.  
9900 Bren Road East  
Minnetonka, MN 55343

***Agent for Service of Legal Process***

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent for Service is:

Plan Administrator – Benefits Administrative Committee  
c/o GEICO Corporation  
One GEICO Plaza  
Washington, DC 20076  
(301) 718-5980

***Other Administrative Information***

This section of your SPD contains information about how the Plan is administered as required by ERISA.

***Type of Administration***

The Medical, Dental and Vision Care Plan is a self-funded welfare plan under the GEICO Corporation Consolidated Welfare Benefits Program and the administration is provided through one or more third party administrators.

|                             |                                                                                                        |
|-----------------------------|--------------------------------------------------------------------------------------------------------|
| <b>Plan Name:</b>           | Medical, Dental and Vision Care Plan under the GEICO Corporation Consolidated Welfare Benefits Program |
| <b>Plan Number:</b>         | 501                                                                                                    |
| <b>Employer ID:</b>         | 52-1135801                                                                                             |
| <b>Plan Type:</b>           | Welfare Benefits Plan                                                                                  |
| <b>Plan Year:</b>           | January 1 – December 31                                                                                |
| <b>Plan Administration:</b> | Self-Insured                                                                                           |

***Your ERISA Rights***

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions (SPD's), by writing to the Plan Administrator. The Plan Administrator may assess a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 7, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by GEICO Corporation's Plan Administrator, the Benefits Administrative Committee. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and GEICO Corporation are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by an In-Network or Out-of-Network provider. UnitedHealthcare and GEICO Corporation are neither liable nor responsible for the treatment, services or supplies provided by In-Network or Out-of-Network providers.

## ATTACHMENT I - HEALTH CARE REFORM NOTICES

### Patient Protection and Affordable Care Act ("PPACA")

#### *Patient Protection Notices*

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the telephone number on your ID card.

For children, you may designate a pediatrician as the Primary Care Provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the telephone number on your ID card.

## **ATTACHMENT II - LEGAL NOTICES**

### **Women's Health and Cancer Rights Act of 1998**

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- 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 treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

### **Statement of Rights under the Newborns' and Mothers' Health Protection Act**

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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