MEBCO

Health Benefit Summary Plan Description
7670-00-412995 / 7670-07-412995 / 7670-11-412995

MEBCO – Mamaroneck Union Free School District

Revised 01-01-2025

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

INTRODUCTION 1

PLAN INFORMATION 2

MEDICAL SCHEDULE OF BENEFITS 5

TRANSPLANT SCHEDULE OF BENEFITS 16

PRESCRIPTION DRUG BENEFITS 17

INCENTIVE SOLUTIONS 18

OUT-OF-POCKET EXPENSES AND MAXIMUMS 19

ELIGIBILITY AND ENROLLMENT 21

SPECIAL ENROLLMENT PROVISION 26

TERMINATION 28

COBRA CONTINUATION OF COVERAGE 32

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 41

PROTECTION FROM BALANCE BILLING 42

PROVIDER NETWORK 44

COVERED MEDICAL BENEFITS 47

TELADOC SERVICES 63

HOME HEALTH CARE BENEFITS 64

TRANSPLANT BENEFITS 65

PRESCRIPTION DRUG BENEFITS 67

HEARING AID BENEFITS 73

MENTAL HEALTH BENEFITS 74

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS 75

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER 76

CENTERS OF EXCELLENCE 80

COORDINATION OF BENEFITS 81

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET 85

GENERAL EXCLUSIONS 88

CLAIMS AND APPEAL PROCEDURES 94

FRAUD 104

OTHER FEDERAL PROVISIONS 105

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION 107

PLAN AMENDMENT AND TERMINATION INFORMATION 111

GLOSSARY OF TERMS 112

MEBCO

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the MEBCO Health Benefit Plan (the "Plan"). You are a valued Participant of the MEBCO Health Plan, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Consortium Employer if You have questions or if You have difficulty translating this document.

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

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

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

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

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document.

This document became effective on October 1, 2017.

PLAN INFORMATION

Plan Name	MEBCO EMPLOYEE HEALTH BENEFIT PLAN
Name And Address Of Employer	MEBCO PO BOX 790 BRIARCLIFF MANOR NY 10510
Name, Address, And Phone Number Of Plan Administrator	MEBCO PO BOX 790 BRIARCLIFF MANOR NY 10510
Named Fiduciary	MEBCO
Claims And Appeals Administrator/Fiduciary For Medical Claims	UMR 2425 JAMES ST SYRACUSE NY 13206 *Note: Not for claim submission.
Employer Identification Number Assigned By The IRS	13-3499774
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	MEBCO PO BOX 790 BRIARCLIFF MANOR NY 10510 Service of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	The level of any Employee contribution is set by collective bargaining agreements with each consortium employer. These contribution levels can be changed through collective bargaining. Benefits are provided by a benefit Plan maintained on a self-insured basis by Your consortium employer.
Collective Bargaining Provisions	The Plan is maintained pursuant to one or more collective bargaining agreements. You may contact your consortium employer for further information.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	January 1 through December 31

Compliance

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

Discretionary Authority

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

Important Numbers	Contact Information	
Name	**Phone/Website**	**Address**
UMR Call to obtain Prior Authorization	Toll-free: 1-800-826-9781 Toll-free: 1-866-494-4502 Website: www.UMR.com	2425 James Street Syracuse, NY 13217
ProAct (Pharmacy Benefit Manager) Customer Service	Toll-free: 1-877-635-9545 Website: www.ProActrx.com	1230 U.S. Highway 11 Gouverneur, NY 13642
MEBCOHealthRx (International pharmacy mail order drug program administered by CanaRx)	Toll-free: 1-866-893-6337 Fax: 1-866-751-6337 Website: www.MEBCOHealth-RX.com	PO Box 44650 Detroit, Michigan 48244-0650
UHC (to find network providers)	Website: www.UMR.com	
UnitedHealthcare Hearing (discounted hearing aids, testing and fitting)	Toll free: 1-855-523-9355 Website:www.uhchearing.com	
UMR Care Management has special program for Cancer Support and Kidney Resource Services	Toll free: 1-866-494-4502	
If You have concerns about a bill or an EOB and suspect fraud, call the toll free hotline	Toll free: 1-800-356-5803	

MEDICAL SCHEDULE OF BENEFITS

Mamaroneck Union Free School District

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

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

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

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

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities. **For out-of-network claims, the maximum reimbursements will not exceed the in-network allowance.**

Please note, an out-of-network provider may balance bill above and beyond the allowed charges.

Out of Country Care. This Plan will provide benefits for Covered charges Incurred outside the USA only for Emergency purposes during temporary travel. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. You may be required to pay the provider at the time of service. If expenses outside the USA are Incurred, You must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where services are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan administrator reserves the right to reimburse the enrollee directly.

	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services Only: • Co-pay Per Visit	 $250	
Plan Copayment: • Co-pay Per Visit	 $25	 Not Applicable
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: • Per Person • Per Employee Plus Spouse • Per Individual Child Or All Children Combined • Per Family ***Note: If You Have Coverage For More Than One Family Member, Any Combination Of Covered Family Members May Help Meet The Maximum Deductible; However, No One Person Will Pay More Than His Or Her Individual Deductible Amount.***	 $0 $0 $0 $0	 $1,000 $2,000 $1,000 $3,000

	IN-NETWORK	OUT-OF-NETWORK
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan	100%	80% (After Deductible)
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Employee Plus Spouse • Per Individual Child Or All Children Combined • Per Family ***Note: If You Have Coverage For More Than One Family Member, Any Combination Of Covered Family Members May Help Meet The Out-Of-Pocket Maximum; However, No One Person Will Pay More Than His Or Her Individual Out-Of-Pocket Amount.***	 $2,500 $0 $0 $5,000	 $4,000 $8,000 $4,000 $12,000
Abortions (elective): • Maximum Benefit Per Member Per Calendar Year • Paid By Plan	 $350 For One Procedure 100%	 80% Of Allowed Charges After Deductible
Ambulance Transportation: • Co-pay Per Trip • Paid By Plan **Volunteer Ambulance (When Covered Person Has No Obligation To Pay):** **Under 50 Miles:** • Paid By Plan **Over 50 Miles:** • Paid By Plan	 $35 100% 50% 75%	 $35 100% (Deductible Waived) 50% (Deductible Waived) 75% (Deductible Waived)
Breast Pumps: • Paid By Plan	 100%	No Benefit
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: • Paid By Plan	100%	80% Of Allowed Charges After Deductible
Durable Medical Equipment: • Paid By Plan	100%	80% Of Allowed Charges After Deductible
Emergency Services / Treatment: **Urgent Care:** • Co-pay Per Visit • Paid By Plan	 $25 100%	 Not Applicable 80% Of Allowed Charges After Deductible

	IN-NETWORK	OUT-OF-NETWORK
Walk-in Retail Health Clinics: • Co-pay Per Visit • Paid By Plan	$25 100%	Not Applicable 80% Of Allowed Charges After Deductible
Emergency Room Only: • Co-pay Per Visit (Waived If Admitted As Inpatient) • Paid By Plan	$100 100%	$100 100% (Deductible Waived)
Emergency Physicians Only: • Paid By Plan	100%	100% Of Allowed Charge (Deductible Waived)
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Co-pay Per Admission • Maximum Days Per Calendar Year • Paid By Plan ***Note: Co-pay Is Waived If Member Is Transferred From A Hospital To A Skilled Nursing/Extended Care Facility.*** ***Note: If Medicare Is The Primary Payor, Inpatient Extended Care Facility Services Are Not Covered.***	$250 30 Days 100%	80% Of Allowed Charges After Deductible
Genetic Counseling: • Paid By Plan	100%	100% (Deductible Waived)
Genetic Testing: • Paid By Plan	100%	100% (Deductible Waived)
Gym Membership / Exercise Facility Reimbursement: • Per Employee / Retiree • Reimbursement Per Six Month Period • Per Spouse / Domestic Partner • Reimbursement Per Six Month Period ***Note: See The Covered Medical Benefits Section Of This SPD For Gym Reimbursement Program Details.***	The Lesser Of $200 Or The Actual Cost Of The Membership Per Six Month Period The Lesser Of $100 Or The Actual Cost Of The Membership Per Six Month Period	
Habilitation Services: **Inpatient Habilitation Services:** • Co-pay Per Admission • Maximum Days Per Condition/Lifetime • Paid By Plan	$250 60 Days 100%	Not Applicable 80% Of Allowed Charges After Deductible

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Habilitation Services:		
• Co-pay Per Visit	$25	Not Applicable
• Maximum Visits Per Condition/Lifetime	90 Visits	
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Hearing Services:		
Exams, Tests:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Hearing Aids:		
• Dollar Maximum Benefit (Every 3 Years)	$3,000 For One Or Both Ears (Including Repair Or Replacement)	
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Implantable Hearing Devices:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Note: See Also, Hearing Aid Program Described Later In This SPD. Maximum For Bone Anchored Hearing Aids Is One Per Ear During The Entire Time Enrolled In Plan. Replacements And/Or Repairs Are Covered Only For Malfunctions. Bone Anchored Hearing Aids Are Covered Only If One Has Either Of The Following: Craniofacial Anomalies Whose Abnormal Or Absent Ear Canals Preclude The Use Of A Wearable Hearing Aid, Or Hearing Loss Of Sufficient Severity That It Would Not Be Adequately Remedied By A Wearable Hearing Aid.		
Hemophilia Factor:		No Benefit
• Co-pay Per Visit	$25	
• Paid By Plan	100%	
Home Health Care Benefits:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, And Up To Four Hours Of Home Health Care Services.		

	IN-NETWORK	OUT-OF-NETWORK
Hospice Care Benefits:		
• Maximum Days Per Calendar Year	210 Days	
Inpatient Hospice Services:		
• Co-pay Per Admission	$250	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Home Hospice Services:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Hospice Services:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Bereavement Counseling:		
• Maximum Visits Per Calendar Year	5 Visits	
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Inpatient Services Only; Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
• Co-pay Per Admission	$250	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Inpatient Physician Charges Only:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Advanced Imaging Charges - Physician:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Advanced Imaging Charges - Facility:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Lab And X-Ray Charges - Physician:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Lab And X-Ray Charges - Facility:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Surgery Only:		
• Co-pay Per Visit	$60	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Surgeon Charges Only:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Infertility Treatment: From Age 21 To Age 44		No Benefit
Advanced Infertility Services:		
• Maximum Benefit Per Lifetime	$10,000	
• Paid By Plan	100%	
Basic Infertility Services:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Infusion Therapy:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Manipulations:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:		
Inpatient Services Only:		
• Co-pay Per Visit	$250	
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Inpatient Physician Charges Only:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Residential Services Only:		
• Co-pay Per Visit	$250	
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Residential Physician Charges Only:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Nursery And Newborn Expenses:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Note: Deductible And / Or Co-pay Will Be Waived For Preventive / Routine Well Newborn Charges, Initial Stay (Days 0-5).		
Orthotic Appliances:		
• Paid By Plan	100%	80% Of Allowed Charges After Deductible
Note: Exclude Custom Molded Foot Orthotics And Non-Custom Molded Inserts.		

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services: • Co-pay Per Visit • Paid By Plan	 $25 100%	 Not Applicable 80% Of Allowed Charges After Deductible
Office Surgery: • Paid By Plan After Deductible	 100%	 80% Of Allowed Charges After Deductible
Diagnostic X-Ray And Laboratory Tests: • Paid By Plan	 100%	 80% Of Allowed Charges After Deductible
Office Advanced Imaging: • Paid By Plan	 100%	 80% Of Allowed Charges After Deductible
Prosthetics: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible ***Note: The Cost Of Replacements For Children (Birth Through Age 19) Is Covered Only If The Previous Device Has Been Outgrown.***	 1 Device, Per Limb 100%	 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: From Age 20 **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan **Immunizations:** • Paid By Plan **Foreign Travel Immunizations:** **Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:** • Paid By Plan	 100% 100% No Benefit 100%	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Mammograms, Breast Exams, Breast Ultrasounds And MRIs:		
From Age 35 To 39		
• Maximum Exams	1 Baseline Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
Preventive / Routine / Diagnostic 3D Mammograms:		
• Paid By Plan	100%	
Preventive / Routine Pelvic Exams And Pap Tests:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
Preventive / Routine PSA Test And Prostate Exams:		
From Age 50 (Or Age 40 At High Risk)		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100%	
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
From Age 45		
• Paid By Plan	100%	
Preventive / Routine Hearing Exams:		
• Paid By Plan After Deductible	100%	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:		
• Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Tobacco Addiction: • Paid By Plan ***Note: Only Covers Counseling By Member's PCP Under The Office Visit Benefit.*** **In Addition, The Following Preventive / Routine Services Are Covered For Women:** ➢ **Treatment For Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Breast Pumps, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100% 100%	
Preventive / Routine Care Benefits For Children Include: To Age 20 **Preventive / Routine Physical Exams:** • Paid By Plan	100%	80% Of Allowed Charges After Deductible
Immunizations: • Paid By Plan	100%	80% Of Allowed Charges After Deductible
Foreign Travel Immunizations:	No Benefit	No Benefit
Preventive / Routine Screenings At Appropriate Ages: • Paid By Plan	100%	80% Of Allowed Charges After Deductible
Preventive / Routine Diagnostic Tests, Lab, And X-Rays: • Paid By Plan	100%	80% Of Allowed Charges After Deductible
Preventive / Routine Hearing Exams: • Paid By Plan After Deductible ***Note: Otoacoustic Testing Covered For Children Under Three Years Of Age Or For Those That Cannot Respond To A Routine Hearing Test.***	100%	80% Of Allowed Charges After Deductible

	IN-NETWORK	OUT-OF-NETWORK
Second Opinion: • Co-pay Per Visit • Paid By Plan	 $25 100%	 Not Applicable 80% Of Allowed Charges After Deductible
Sterilizations: • Paid By Plan	 100%	 80% Of Allowed Charges After Deductible
Teladoc Services: **General Medicine:** • Co-Pay Per Occurrence • Paid By Plan ***Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.***	 $10 100%	 $10 100% (Deductible Waived)
Temporomandibular Joint Disorder Benefits: • Paid By Plan ***Note: Plan Excludes Dental Procedures And Appliances. Surgical/Non-Surgical Medical Procedures May Be Covered With Prior Authorization. If Caused By An Underlying Medical Condition, It Will Be Covered. If Related To A Dental Condition, It Will Not Be Covered.***	 100%	 80% Of Allowed Charges After Deductible
Therapy Services: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan **Physical Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Paid By Plan ***Note: Covered Only When Related To The Treatment Or Diagnosis Of A Physical Illness Or Injury. In Children, This Includes A Medically Diagnosed Congenital Defect.***	 $25 90 Visits 100% $25 100%	 Not Applicable 80% Of Allowed Charges After Deductible Not Applicable 50% Of Allowed Charges After Deductible
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment: • Paid By Plan	 100%	 100% (Deductible Waived)
All Other Covered Expenses: • Paid By Plan	 100%	 80% Of Allowed Charges After Deductible

TRANSPLANT SCHEDULE OF BENEFITS Mamaroneck Union Free School District	
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan	 100%

PRESCRIPTION DRUG BENEFITS

Mamaroneck Union Free School District

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact Your Consortium Employer or the PBM Help Desk at 1-877-635-9545 with any questions related to this coverage or service.

Prescription drug benefits are generally separate from medical benefits and do not apply to the deductibles and copayments for medical benefits.

The Plan will follow The Provision Of Federal Patient Protection And Affordable Care Act as it pertains to the preventive care provisions of the Plan. No patient cost share is required for generic drugs mandated as covered under this provision. If a generic version is not available or would not be medically appropriate for the patient as determined by the attending physician, the brand name drug will be available at no cost share, subject to reasonable medical management approval by ProAct (PBM). Contact the PBM Customer Service Department toll-free at 1.877.635.9545 for details.

Any one retail pharmacy prescription or refill is limited to a 30-day supply. Any one mail order prescription or refill is limited to a 90-day supply. Some covered prescription drugs have a quantity limit under the Plan. For additional information on medications that have quantity limits You may call the PBM.

Covered Drugs And Supplies MEBCO Primary Option	**In-Network And Out-Of-Network**
Prescription Drug Benefit (ProAct)	**Note:** *You Must Pay Applicable Copayments. The Plan Pays The Balance Of Allowable Fees.* Copayments Per Prescription: **Retail** (Up To A 30 Day Supply) / **Retail** (31-90 Day Supply) / **Mail Order** (Up To 30 Day Supply) / **Mail Order** (31-90 Day Supply) / **Specialty** (Up To A 30 Day Supply) / **Specialty** (31 90 Day Supply) **Generic**: $15 / $10 / $5 / $30 / $15 / $10 **Brand Name**: $25 / $50 / $25 / $50 / $25 / $50 **Non-Preferred Brand Name**: $40 / $90 / $45 / $80 / $40 / $90 Co-Pay Waived On Brand Name Drugs Via MEBCOHealthRx.
Prescription Drug Deductible	$75 Per Individual (Employee/Retiree, Spouse Or Child) $150 Per Family
Prescription Drug Out-Of-Pocket Limit	$4,850 Per Individual (Employee/Retiree, Spouse Or Child) $9,700 Per Family
	Once The Out-Of-Pocket Limit Is Met, The Remainder Of The Covered Charges Are Payable At 100% Of The Allowed Charges For The Remainder Of The Calendar Year.

INCENTIVE SOLUTIONS

You may be offered incentive rewards to encourage You to participate in various health and wellness programs or healthy activities. The decision about whether or not to participate is Yours alone, and MEBCO recommends that You discuss participating in such programs with Your Physician. For additional information and answers to questions concerning incentives, please contact Your Human Resources or Personnel office.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

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

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits.

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

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

PLAN PARTICIPATION

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

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

ANNUAL OUT-OF-POCKET MAXIMUMS

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

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

- Medical out-of-network Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy Co-pays and Plan Participation amounts for Prescription benefits.

- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

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

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

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

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly meets the minimum requirements shown below and/or any modifications established by his or her Consortium Employer. (Note: As required by the Patient Protection and Affordable Care Act, Waiting Periods for coverage cannot exceed 90 days.)

Active Employee of the employer must be:

- Hired by the Consortium Employer for anticipated full-time employment of three or more months; and
- Timely enrolled. The enrollment will be "timely" if the completed form is received by the Plan administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period; and
- Scheduled to work and regularly works 20 hours or more a week for his or her Consortium Employer; or
- In one of the following categories with the Consortium Employer:

  - A paid elected official;
  - A paid member of a public legislative body;
  - An elected member of a school board;
  - Be paid an annual salary at a rate of $2,000 or more per year, or
  - If paid less than $2,000 per year, Your major source of family income must be from Your public employment.

MODIFICATIONS OF MINIMUM REQUIREMENTS

A Consortium Employer may modify the minimum requirements shown above in the following ways:

- By increasing the minimum period of anticipated employment from three months to as much as six months;
- By establishing a regularly scheduled work week of more than 20 hours;
- By requiring a minimum annual salary of more than $2,000; or
- By excluding paid elected officials, paid members of public legislative bodies or elected members of school boards.

For purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

- Any person who is employed by a public educational institution on other than a full-time basis and who is also a student therein enrolled for a degree.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which is combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until death.

An **eligible Dependent** includes:

- Your legal spouse means a person recognized as Your husband or wife under the laws of the state or other jurisdiction where You live or were married. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married and Domestic Partners of eligible Employees or Retirees at a time before same-sex marriage was legally permissible. The Plan Administrator may require documentation proving a legal marital relationship or Domestic Partner status.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's or Domestic Partner's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A Qualified Dependent.

- A covered Employee's Qualified Dependents. The term "Qualified Dependent" means any other unmarried Child who is not a biological Child, legally adopted Child (including a pre-adoptive newborn and a Child placed for adoption), foster Child, or stepchild and who is:

  - Under age 19; or
  - Over 19 years of age but under 25 who receives more than half their support from the Employee and is a full-time matriculating student at an accredited secondary school, college or university.

  The Qualified Dependent must be supported by the Employee or the spouse of the Employee and permanently reside in the Employee's home, provided the support and residence commenced before the Child reached age 19.

  A Qualified Dependent includes a Child for whom the Employee is a Legal Guardian.

Time spent in the U.S. Military service, not to exceed four years, may be deducted from the Dependent's age for the purposes of establishing eligibility.

In the event a Qualified Dependent Child who is a full-time student becomes disabled and is granted a medical leave by the school he or she is attending, benefits will continue for a maximum of 12 calendar months following the month in which the Child withdraws from school. If the end of the 12 calendar months occurs during a vacation period, benefits will be extended to the beginning of the next regular semester.

In the event an unmarried Qualified Dependent Child between the ages of 19 and 25 who previously was not eligible for benefits or had benefits ended returns to a full-time student status, may be reinstated to family coverage effective the actual date the student commenced full-time attendance at the high school or an accredited institute of higher learning.

Federal law ("Michelle's Law") mandates that coverage will not terminate if the covered Dependent Child's failure to maintain full-time status at a postsecondary educational institution is due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the Child's treating Physician certifies in writing that the Child is suffering from a serious Illness or Injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the Child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. However, this extension does not extend coverage beyond the date that a Child fails to meet the Dependent eligibility requirements other than the requirement to be a full-time student.

To obtain Plan coverage for full-time students, You may be required to document, at least annually, appropriate certification of this fact to Your Consortium employer. Failure to provide the required information when requested will result in that Child being removed from enrollment and eligibility for benefits until proof is provided which supports continued eligibility for Plan enrollment.

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - Any other relative or individual unless explicitly covered by this Plan.

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

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
- A Totally Disabled Dependent Child age 26 or over must be unmarried.

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

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

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

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

- The Dependent Child was covered by this Plan on the day before the Child's limiting age; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the limiting age and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof no more than twice per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than limiting age who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

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

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

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within 30 days of hire, Your coverage will become effective Your date of hire; or

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 calendar days of the event.

In addition, Your Consortium Employer may (a) establish a policy to provide Employees with benefits on the first day of eligible employment if benefits are applied for on or before that date, or (b) establish a minimum period of employment of no more than 90 days before new Employee coverage starts.

If You enroll at the time of eligible retirement, Retiree coverage begins on Your date of retirement. Consortium Employers establish their own rules for assigning effective dates for Retired Employees and/or eligible Dependents who wish to late enroll for coverage: consult with Your Consortium Employer to obtain specific information on the effective date, if any, for You or Your eligible Dependents.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

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

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 calendar days of acquiring the Dependent; or
- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 30 calendar days following the event; or
- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents. The policy for Retiree enrollment and changes is determined by each Consortium Employer.

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

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

For additional information, see Your Consortium Employer.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

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

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of new Dependents.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other health coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and

- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

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

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

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

Change Between Options/Coverages: If an Employee elects to change options (example: Bronze to Primary or Primary to Bronze) during a special enrollment period, any monies accumulated towards Deductibles, Out-of-Pocket limits and all other limits will carry over from the prior option. If an Employee elects to change from individual to family coverage during a special enrollment period, any monies accumulated towards Deductibles and Out-of-Pocket limits will carry over.

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

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 30 calendar days of the marriage, birth, adoption, or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

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

TERMINATION

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

The Consortium Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Consortium Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Consortium Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. If contributions are required, the Consortium Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

EMPLOYEE'S COVERAGE

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

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to the date the employer ends the continuance, provided the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The date in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

- The day of the month in which Your coverage ends except that in the event that the Employee dies, enrollment eligibility for the Dependent may continue at the time of a vested Employee's or eligible Retiree's death.

- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

Survivor Spouse Eligibility. Your Dependent Spouse enrolled in your family coverage at the time of a vested Employee's or eligible Retiree's death will maintain Plan enrollment eligibility.

See Vested Employee Continuation of Coverage shown later in this section.

Direct continued payment of a designated contribution is needed to maintain continued coverage.

Enrollment as a survivor spouse must be requested within 30 days from the date of the vested Employee's or Retiree's death. If enrollment not requested within 30 days or if the spouse decides not to retain coverage, he or she cannot later enroll for coverage under this provision.

If the survivor spouse remarries, eligibility and coverage would cease on the date of marriage. In this event, the survivor spouse could be eligible for Continuation of Coverage Rights under COBRA shown later in this section.

Survivor Dependent Children are not covered under this rule. Survivor Children and spouses not covered under this provision could be eligible for COBRA continuation.

Civil Service Preferred List. A person who is on the civil service preferred list of a Consortium Employer is eligible for individual or family coverage enrollment for a maximum of 12 months, while waiting for active employment. To be eligible for coverage, he or she must remit both the Employee's share and the Consortium Employer's share of the monthly participation contribution to the Consortium Employer.

Vested Employee Continuation of Coverage. Each Consortium Employer's rules may differ from the general rules shown below. Your Consortium Employer can provide details concerning their established rules and costs for vested Employee coverage, if available. This continuation of coverage counts toward COBRA continuation periods.

- General Eligibility Rules for Vested Rights. Generally enrolled Employees who terminate their employment before retirement age may continue their health coverage at the option of the Consortium Employers if:

  - The Employee has ten years of paid service (during which you are eligible for health benefits) with any Consortium Employer; or
  - The Employee has five years of paid service (during which you are eligible for health benefits) with any Consortium Employer and another five years with any agency in which the Employee was enrolled in the same retirement system.
  - The five years of paid service employment requirement is waived for elected officials and appointed department heads who have been enrolled in the same retirement system for the requisite minimum of ten years.
  - Employees with vested rights who are enrolled in a Participating Consortium Employer-sponsored Health Maintenance Organization (HMO) program or similar plan may not be eligible to continue coverage in that plan after termination of eligible employment. However, they will have the opportunity to continue coverage in this Plan. Your Consortium Participating Employer can provide details concerning your eligibility to continue health coverage as a vested Employee.

- Requesting Continuation of Coverage While in a Vested Status. If You wish to continue this health Plan while You are vested, You must request continuation of coverage from Your Consortium Employer at the time employment is terminated. If continuation of coverage is authorized by Your Consortium Employer, You will be required to pay part of the Plan Contribution from the date You are terminated until You are eligible to receive a retirement allowance. These amounts will be at least 50% of the individual coverage Plan Contribution or 65% of the Plan contribution for family coverage. A bill will be sent to You indicating the amount due each quarter. Your Consortium Employer will assist You with the procedures required to keep Your coverage in effect.

If Your coverage ends because you made no request to continue coverage, or failed to make participating payments during vested continuation coverage, You will not be permitted to reinstate your coverage either during the remainder of your vested status period or after retirement. Once You have established eligibility to continue health Plan coverage as a vestee, that eligibility will not be impaired by subsequent employment

RESCISSION OF COVERAGE

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

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

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

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 3 months from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 3 months from the date Your coverage ended, and You did not perform any hours of service that were credited within the 3 month period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Consortium Employer.

COBRA CONTINUATION OF COVERAGE

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

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

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

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

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

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

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

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

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

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

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

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

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

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

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

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

COBRA continuation coverage for Retired Employees and their Dependents is described below:

Qualifying Event	**Length of Continuation**
• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent’s coverage is also terminated, Your spouse and Dependent Children will also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code, the bankruptcy may be a Qualifying Event. If the bankruptcy results in the Retired Employee’s Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee’s spouse or surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➢ Retired Employee	Lifetime
➢ Dependents	36 months

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

COBRA NOTICE PROCEDURES

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

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

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

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

Send all notices or other information required by this Summary Plan Description in writing to:

UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824

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

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

- The date of the Qualifying Event; or

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

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

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

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

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

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

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

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

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

PAYMENT FOR CONTINUATION COVERAGE

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

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

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

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

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

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him or her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

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

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

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

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

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

- A Child is born to, adopted by, or Placed for Adoption with a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or Your Consortium Employer requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

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

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

- For Retired Employees and Dependents of Retired Employees only: If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries may elect COBRA continuation coverage for the following maximum periods, subject to all COBRA regulations. The covered Retired Employee may continue COBRA coverage for the rest of his or her life. The covered spouse or surviving spouse or the Dependent Child of the covered Retired Employee may continue coverage until the earlier of:

  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

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

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

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

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

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

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

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

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

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

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

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA CONTINUATION

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

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

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

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

DEFINITIONS

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

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

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

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

IF YOU HAVE QUESTIONS

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

The Plan Administrator:
MEBCO
2425 JAMES ST
SYRACUSE NY 13206

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

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

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

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

USERRA NOTICE AND ELECTION

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

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

PAYMENT

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

EXTENDED COVERAGE RUNS CONCURRENTLY

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

PROTECTION FROM BALANCE BILLING

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

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

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

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

ALLOWED AMOUNTS

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

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

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

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

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

OUT-OF-NETWORK BENEFITS

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

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

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

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

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

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

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

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

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

PROVIDER NETWORK

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

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

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

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

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

  UnitedHealthcare Choice Plus

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

The program for Transplant Services at Designated Transplant Facilities is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

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

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services provided by a Physician (excluding surgeons) during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Wigs, toupees, and hairpieces will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
  Note: (Applies to above bullets) Deductible waived and provider may balance bill up to the amount of charges.

- The attending Physician for conditions other than surgery or obstetrical care will usually be covered for one visit per day. Additional Physicians or Physician visits will be considered when found Medically Necessary according to Plan provisions, for example, when patient's Illness is so critical or serious it requires more attention by the Physician. Also, care by more than one Physician will be considered when each provider gives medically required treatment for separate and different conditions.

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. Information is available at www.umr.com or call UMR Customer Service toll free 1-800-826-9781. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may require a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

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

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

You or Your Dependent must call UMR within 30 days prior to Your Effective Date or within 30 days after Your Effective Date to see if You or Your Dependent is eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, treatment for minor Illnesses, and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network. Retiree-only plans are not subject to the Continuity of Care requirements.

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

- Undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or

- A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;

- Undergoing Inpatient or institutional care;
- Scheduled for non-elective surgical care, including necessary postoperative care;
- Pregnant and being treated; or
- Terminally ill and receiving treatment for such Illness by a provider or facility.

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

COVERED MEDICAL BENEFITS

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

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

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

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

2. **Abortions (Elective).**

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

4. **Ambulance Transportation:**

   - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
   - Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

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

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

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

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

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

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

9. **Biofeedback Services.**

10. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Benefits for breast pumps include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.

11. **Breast Reductions** if Medically Necessary.

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

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

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

    Covered services include:

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

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

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

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

18. **Consultations, Specialist** (inpatient, outpatient).

19. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that require that a Physician administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

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

21. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if Medically Necessary.

- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

22. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling. This benefit also includes glucose monitors, test strips for glucose monitors, visual reading and urine testing, lancets and automatic lancing devices, injection aids, cartridges for the legally blind syringes, and data management systems.

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

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

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

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

25. **Emergency Medical Services Provided in a Foreign Country**, except that no coverage is provided if, the member permanently resides in a foreign country and/or the sole purpose of travel to that country is to obtain medical services and/or supplies.

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

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

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

    Note; if Medicare is the primary payor, inpatient extended care facility services are not covered.

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

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

- Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
- Treatment of corns, calluses, and toenails.

- Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

30. **Gender Dysphoria (Mamaroneck Schools only):**

Note: This medical policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

In the requirements set forth below, "qualified mental health professional" includes certified and licensed: psychiatrists, clinical psychologist, psychiatric nurse practitioners, psychiatric physician assistants, psychotherapists/counselors, and social workers, or any health professional with behavioral health training and experience.

Gender reassignment surgery may be indicated for individuals who provide the following documentation:

- For genital surgery:
  - A written psychological assessment from at least two qualified mental health professionals who have independently assessed the patient. If the first referral is from the patient's psychotherapist, the second referral may be from a person who has only had an evaluative role with the patient, whether mental health professional or primary care provider.
  - Two separate letters, or one letter signed by both (e.g. if both professionals are practicing within the same clinic) may be sent. Each referral letter is expected to cover the same topices in the following areas:
    1) The client's general identifying characterstics;
    2) Results of the client's psychosocial assessment, including any diagnoses;
    3) The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
    4) An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
    5) A statement that informed consent has been obtained from the patient; and
    6) A statement that the treating professional is available for coordination of care.
- For chest surgery:
  - Hormone therapy is not a prerequisite
  - One referral from a qualified mental health professional is needed for chest surgery

When the above criteria are met, the following gender reassignment surgical procedures are medically necessary and covered as a proven benefit:

- Mammoplasty
- Subcutaneous Mastectomy
- Nipple grafts
- Chest Reconstruction
- Nipple areola reconstruction
- Electrolysis as part of a genital surgery skin graft
- Facial Reconstruction surgery
- Electrolysis or laser hair removal
- Hair reconstruction
- Voice Surgery

- Liposuction
- Lipofilling

The following specific surgeries are also considered medically necessary and covered as a proven benefit:

- Male-to-Female (MtF):
  - 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)
  - Vulvoplasty (removal of skin folds around the vulva)
  - Prostatectomy (removal of prostate gland)
  - Laryngoplasty (rebuild vocal cords)
  - Glottoplasty(shortening the vocal cords)
  - Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
  - Lipoplasty (removal of fat)
  - Breast enlargement, including augmentation mammaplasty and breast implants
  - Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the
  - Adam's apple)
  - Mastopexy (breast lift)
  - Liposuction (suction-assisted lipectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)

- Female-to-Male (FtM):
  - 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 prostheses
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)
  - Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
  - Laryngoplasty (rebuild vocal cords)
  - Glottoplasty (shortening the vocal cords)
  - Lipoplasty (removal of fat)
  - Liposuction (suction-assisted lipectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)

*Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Certain ancillary procedures, including but not limited to the following, are considered cosmetic and/or not Medically Necessary, when performed as part of gender reassignment:

- Abdominoplasty (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Body contouring (e.g., panniculectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Calf implants
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
- Voice lessons and voice therapy

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

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

Genetic testing MUST meet the following requirements:

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

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

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

Generally, genetic testing is not covered for:

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

33. **Gym Membership / Exercise Facility Reimbursement (Mamaroneck Schools Only):**

Employees/Retirees and their spouses who are participating in the health plan will be eligible to receive reimbursement for active participation at their local gym. Maximum payout for the employee/retiree is $200 every six months (total of $400 for a calendar year) and $100 for the spouse every six months (total of $200 for a calendar year). Members must complete 50 visits at a fitness studio/gym within a 6 month period and submit documentation and paid receipt to UMR.

The Plan will partially reimburse You for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities and which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. The Plan will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages etc.).

In order to obtain reimbursement, at the end of the six-month period You must:

- Submit a completed reimbursement form.
- Submit a copy of Your current facility bill which shows the fee paid for Your membership.

Once the Plan receives the completed reimbursement form and the bill, You will be reimbursed as identified in the schedule of benefits.

34. **Habilitation Services:**

Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

35. **Hearing Services** include:

- Exams, tests, services, and supplies to diagnose and treat a medical condition.
- Purchase or fitting of hearing aids.
- Implantable hearing devices. See also, Hearing Aid Program described later in this SPD.

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

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

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

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

Day care service provided by the Hospice Agency; Home care and Outpatient Services provided by the Hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a home health aide.

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

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

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

39. **Hospital Services (Outpatient).**

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

40. **Infertility Treatment** has the meaning set forth in the regulations of the New York State Insurance Department. In general, Infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse, as further defined in the regulations. Expenses related to the procurement of eggs, sperm, or embryos from or donated by the patient or his or her spouse are covered only when part of an approved course of treatment for artificial insemination or in vitro fertilization or similar procedures. If not part of an approved course of treatment, the procurement expenses are not covered, whatever the reason. All expenses related to a donor other than a spouse for the procurement of eggs, sperm or embryos or similar services are not covered, whatever the reason. Coverage is not provided for the Infertility or artificial conception services and supplies related to surrogate pregnancies. Expenses related to the freezing and storage of eggs, sperm, or embryos are not covered, whatever the reason.

Benefits will be allowed for covered services in the same manner as an Illness based on type of services received. Coverage includes services and supplies for hormonal therapy, artificial insemination, sonograms, in vitro procedures and other treatment that meets the protocol established by the American College of Obstetricians and Gynecologists (ACOG).

Infertility services are covered In-Network only; no Out-of-Network coverage. Participants must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services.

Basic infertility services consist of: initial evaluation, semen analysis, laboratory examination, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

Advanced Infertility services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), culture and fertilization of oocyte(s), culture and fertilization of oocyte(s) with co-culture of embryos, assisted oocyte fertilization, microtechnique (any method), assisted embryo hatching, microtechnique (any method), oocyte identification from follicular fluid, preparation of embryo for transfer (any method), ultrasonic guidance for aspiration of ova, imaging and supervision; and MESA/TESA procedures. MESA/TESA procedures are available only when the male has an abnormally low sperm count or the male's sperm has difficulty penetrating the ovum. Mamaroneck Schools end.

The following coverage limits apply:

- Infertility Care. Coverage is available for up to six ovulatory cycles per course of treatment within two years when non-experimental infertility medications are used. To obtain coverage approval for a course of treatment, the doctor must provide a statement of Medical Necessity including details on condition, medical history, previous treatment and proposed treatment. The Claims Administrator will advise whether coverage is available according to Plan limitations and exclusions. Benefits are limited to the following:

  - Initial course of Infertility Treatment up to six ovulatory cycles within two years.
  - If the first treatment course is not successful (does not result in confirmed pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent infertility care expenses.
  - If the treatment course is successful (results in confirmed pregnancy) within six cycles, coverage becomes available for a second course of Infertility Treatment when pre-approved by the Claims Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent Infertility care.
  - Exhausted coverage or benefit is for a Lifetime.

- Artificial Insemination. Coverage is limited to artificial insemination when needed due to a medical condition of the patient or due to abnormal male (spouse of the patient) factors contributing to Infertility. Coverage is available for up to a maximum of six ovulatory cycles per course of treatment within two years. This course of treatment must be pre-approved for coverage by the Claim Administrator. To obtain coverage approval for a course of artificial insemination, the doctor must provide a statement of Medical Necessity including details on condition, medical history, previous Infertility or artificial insemination treatment and proposed treatment Plan. The Claims Administer will advise whether coverage is available according to Plan limitations and exclusions.

  Benefits are limited to the following:

  - An initial course of artificial insemination up to six ovulatory cycles within two years.
  - If the treatment course is not successful (does not result in confirmed Pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent artificial insemination expenses.
  - If the initial course of treatment is successful (results in confirmed Pregnancy) within six cycles, coverage becomes available for a second course of artificial insemination treatment when pre-approved by the Claims Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent artificial insemination treatment.
  - Exhausted coverage or benefits are for a Lifetime.

- In-vitro Fertilization. Coverage is available for in-vitro fertilization, gamete inter-fallopian (GIFT) which attempted retrieval has occurred. To obtain coverage approval for a course of treatment, the Physician must send the Claims Administrator a statement of Medical Necessity including details on condition, medical history, history of previous Infertility care and/or unsuccessful attempts to start a Pregnancy and his or her proposed treatment plan. The Claims Administer will advise whether coverage is available according to Plan limitations and exclusions. Benefits are limited to the following:

  - Initial course of in vitro treatment up to three ovulatory retrieval cycles within 1 ½ years.
  - If the treatment course is not successful (does not result in confirmed Pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent in vitro expenses.
  - If the first treatment course is successful (results in confirmed Pregnancy) within three retrieval cycles, coverage becomes available for a second course of in-vitro treatment when pre-approved by the Claims Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent Infertility care.
  - Exhausted coverage or benefits are for a Lifetime.

41. **IV Infusion Therapy.**

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

43. **Life-Threatening Disease or Condition Exception to Experimental, Investigational, or Unproven Treatment.** Subject to medical review, an Experimental, Investigational, or Unproven drug, supply, care, treatment, or service may be considered eligible for coverage in the event of a Life-Threatening Disease or Condition (one that is likely to cause death within one year of the request for treatment), if it is determined to be:

    - Safe with promising efficacy, but unproven, and
    - Used within a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health (NIH).

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

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

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

46. **Mental Health Treatment.** (Refer to Mental Health section of this SPD).

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

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

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

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

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

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

51. **Oral Surgery** includes:

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

52. **Orthognathic, Prognathic, and Maxillofacial Surgery** when Medically Necessary.

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

54. **Oxygen and Its Administration.**

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

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

57. **Physician Services** for covered benefits.

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

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

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

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

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

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

  Please visit the following links for additional information:

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

Covered Persons must use an in-network provider; however, benefits are available for annual routine health exams or general physicals rendered by out-of- network providers for active Employees, age 50 or older, or for an active Employee's spouse age 50 or older. Coverage includes related routine tests and is limited to once per calendar year.

Out-of-network benefits are not payable for Retiree or Retiree Dependents or for Covered Persons under age 50. In addition, this benefit is not available if a Covered Person was already reimbursed for a routine health exam during the same calendar year under the in-network benefit provisions.

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

- Due to the growth or development of a Dependent Child; or

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

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

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

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

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

Routine patient care costs for Qualifying Clinical Trials may include:

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

Routine costs for clinical trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);

- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
- The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - It is comparable to the system of peer review of studies and investigations used by the NIH; and
  - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

63. **Radiation Therapy and Chemotherapy.**

64. **Radiology and Interpretation Charges.**

65. **Reconstructive Surgery** includes:

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

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

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

68. **Sleep Disorders** if Medically Necessary.

69. **Sleep Studies.**

70. **Speech Therapy.** (See Therapy Services below and the excluded services section which lists speech therapy when associated with developmental delays as an excluded service.)

71. **Sterilizations.**

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

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

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedure; 50% of the Usual and Customary charge will be allowed for each additional procedure performed during same operative session.
- If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure.

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

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

76. **Temporomandibular Joint Disorder (TMJ) Services** include:

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

Coverage does not include orthodontic services.

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

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder. (See excluded services section which lists speech therapy when associated with development delays.)

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

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

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

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

82. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment.

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

TELADOC SERVICES

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

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

Teladoc may be used:

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

Teladoc can be used for the following types of conditions:

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

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

Teladoc does not guarantee that every consultation will result in a Prescription. Medications are prescribed at the Physician's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after his or her consultation to call Teladoc with any clarification questions. A member of the Teladoc clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another Physician consultation, he or she will be charged the Teladoc consultation fee.

Teladoc may not be used for:

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

HOME HEALTH CARE BENEFITS

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

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

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

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

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

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

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

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

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

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

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

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

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

BENEFITS

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

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

COVERED EXPENSES

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

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

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

Benefits are payable only for Approved Transplant Services.:

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

SECOND OPINION

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

TRANSPLANT EXCLUSIONS

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

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

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

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

- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial or Life-Threatening Disease or Condition exception.

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

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

PRESCRIPTION DRUG BENEFITS

Administered by ProAct

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

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

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. ProAct is the administrator (the PBM) of the Pharmacy drug plan.

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Contact the PBM Customer Service Department toll-free at 1.877.635.9545 for details.

Copayments

If You purchase a name brand drug you could be responsible for the payment of charges more than the cost of the Generic Drug substitution and the Copayment shown in the Summary of Benefits. See Mandatory Generic Drug Substitution Program shown below.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's Member ID card is not used, the Covered Person must pay the pharmacy and submit a claim for benefits to the PBM. You will be reimbursed up to the usual and reasonable cost of the covered prescription drugs less the Copayment and Mandatory Generic Drug restrictions, if applicable. To file a claim for benefits, obtain a drug claim form from ProAct or Your Consortium Employer. The original drug receipt (receipt should include dates of purchase, names of drug, dose and Rx #) and the completed drug claim form should be mailed *to the PBM*.

Copayment is waived for generic prescription drugs that are mandated as covered under the “Preventive Care” provisions of the federal Patient Protection and Affordable Care Act. If a generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the brand name drug will be available at no cost share, subject to reasonable medical management approval by the PBM. Contact the PBM Customer Service Department for details on quantity limits and “Preventive Care” provisions under the Plan.

Out-of-Pocket Limit

Covered Expenses are payable at the percentage shown each calendar year until the Out-of-Pocket shown in the Summary of Benefits is reached. Then, covered Prescription Drug Expenses Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the remainder of the calendar year.

Mail Order Drug Benefit

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

For maintenance drugs, two fills (original fill and one refill) for a new prescription may be filled at a retail pharmacy before the mail service pharmacy becomes mandatory.

Your Physician can also call the PBM for instructions for electronic submission of a prescription.

MEBCOHealth-RX

MEBCOHealth-RX is a voluntary program available to eligible Enrollees, Retirees and their Dependents, is a cost- saving, international mail order drug program for brand name prescriptions administered by CanaRx. Participation in the MEBCOHealth-Rx program is strictly voluntary and does not replace Your current prescription benefit plan.

Advantages of joining the MEBCOHealth-Rx program are:

- **$0 COPAY** for all prescriptions offered through the program
- Prescriptions shipped directly to your home with no shipping and handling costs
- No Out-of-Pocket expenses
- A list of brand name prescription medications is available. See contact information below.

How does it work?

- Request a formulary list of Brand Name prescriptions (see contact information below) to determine if any of Your current medications are available through this program
- Before ordering through CanaRx, You or Your doctor must attest that You have been taking Your prescribed medication for at least 30 days - this is to ensure You have not experienced any complications with the medication
- Ask Your doctor for a prescription for a 3-month supply with 3 refills
- Request Your doctor to fax Your enrollment form and prescription directly to MEBCOHealth-Rx-

  OR Mail
- Your original prescription and completed enrollment form to MEBCOHealth-Rx
- Include a new prescription for each medication being ordered
- CanaRx will call You prior to each refill to ensure that You have a continuous supply of medications
- Allow four weeks for delivery when ordering new medications.

CanaRx Contact Information:

- Mail MEBCOHealth-Rx, PO Box 44650, Detroit, Michigan 48244-0650
- Fax 1.866.715.(MEDS) 6337
- Phone 1.866.893.(MEDS) 6337
- Website www.MEBCOHealth-Rx.com

Should You have any questions regarding the MEBCOHealth-Rx program, please call the CanaRx toll-free phone number 1.866.893.6337 with Your questions.

Remember… this is a voluntary program and does not replace Your current ProAct prescription benefit plan.

Pre-authorization Requirements

Some drugs require pre-authorization before benefits become available. The participating pharmacy or mail order pharmacy will not provide coverage unless drugs have been approved for benefit payment.

If a pharmacy advises You that you need pre-authorization, You should call the ProAct, the PBM, for assistance. Failure to obtain prior authorization will result in denial of benefits.

Specialty drugs
Retin-A/Avita from age 26
Sporonox
Lamisil
Gleevec
Iressa
Anti-obesity agents
Fertility agents
Thalomid (limited to 28-day supply)

Specialty Pharmacy Services

The PBM has a special program for specialty drugs developed for chronic and or complex Illnesses including but not limited to Crohn's disease, hepatitis C, osteoarthritis, rheumatoid arthritis, Infertility, and pulmonary disease. These drugs may have special handling storage, shipping requirements, or require disease specific treatment programs. They may be injections, infusions, or oral products.

Specialty drugs require preauthorization.

All drugs deemed specialty drugs by the PBM will be sent to the Noble Specialty Pharmacy to be filled. A complete list of drugs available under the specialty Pharmacy is available by calling the PBM's toll-free number or You may access the list on their website at www.ProActrx.com.

Vacation Supply

A supply of medication may be replenished before a normal refill date when needed for a vacation trip. To obtain authorization for an advance supply of drugs, You must phone the PBM. You must pay the applicable multiple Copayments for a vacation supply.

Mandatory Generic Drug Substitution Program

As part of a continuing effort to control costs and preserve the quality of the Plan, You are encouraged to use generic drugs whenever appropriate for your condition. A generic drug is chemically equivalent to the original brand name drug. The only difference is that the brand name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the generic manufacturer does not incur research costs and can charge significantly less for the drug. Since generic drugs cost less than brand name drugs, cost savings result for You (a lower percentage payable liability amount) and the Plan when You substitute the lower priced drug. If you have any questions about generic drugs, ask for advice from Your Physician or Your pharmacist.

Noncompliance Benefit Reduction:

Under the PBM program, if You or your eligible Dependent receive a brand name drug when a generic drug substitution is available, You are responsible for paying the difference between the cost of the brand name drug and the generic drug and the applicable Copayment for the brand name drug.

Certain drugs are excluded from this mandatory requirement: Coumadin, Dilantin, Lanoxin, Levothyroid, Mysoline, Premarin, Synthroid, and Tegretol. You pay only the applicable Copayment for these brand name drugs with generic equivalents.

Drug costs will be based on the participating pharmacy prices as established by the PBM. This can result in substantial payment by You as there may be a significant difference in costs between the expensive brand name drug and the lower priced generic drug.

Medical Exception. If the attending Physician considers the generic drug substitute to be harmful to the Covered Person's health, then the Plan will allow coverage for the costs of the brand name drug. To qualify for this exception, the Physician must provide written specific reasons why the generic drug is harmful to You or Your Dependent's health. This exception will not apply if the Physician just wants to prescribe that particular brand name drug. The Physician may fax his/her written statement to the PBM. **Prior authorization is required for any exceptions to this mandatory generic drug program.** It will be promptly reviewed and, if approved, You will be able to obtain the brand name drug each time it is purchased. If You have any questions concerning this procedure, You may contact the clinical coordinator at the PBM.

Benefits will continue to be paid for brand-name drugs which have no generic drug equivalent.

However, when a prescription is written for a brand-name drug and a generic drug substitute is available and if the doctor fails to specify no substitution or if the medical exception is not approved, Plan payment will be limited to that of the equivalent.

Preferred Drug Step Therapy Program

Step therapy refers to a patient initially using a less costly prescription medication ("first-line drug") before using a more expensive Prescription Drug ("second line drug") to treat a chronic condition.

A "second-line drug" can also be used to relieve immediate symptoms, then maintenance therapy is achieved with a "first-line drug." But if the "first-line drug" is unsuccessful, the patient is stepped up again to a "second-line drug."

The Preferred Drug Step Therapy Program applies to the following non-covered "second-line drugs":

Aciphex, Kapidex®, pantoprazole, Prevacid®, Prilosec® packets, Protonix®, Zegerid®

Actonel®, Actonel with calcium

Ambien CR™, Lunesta®, Rozerem®

Beconase AQ®, Flonase®, Nasacort/Nasacort AQ®, Nasarel®, Rhinocort AQ®, Veramyst, Omnaris

Amerge®, Axert®, Frova®, Maxalt®, Maxalt MLT®, Treximet®, Zomig®, Zomig ZMT®

Atacand/Atacand HCT, Benicar/Benicar HCT, Avapro, Avalide, Teveten/HCT

After You have been taking one of these drugs for 90 days, you can choose:
(1) to get a prescription for a lower cost alternative ("first-line drug"), or
(2) pay the entire cost of the non-covered Prescription Drug, or
(3) request of coverage review of the non-covered medication. Continued use of a non-covered prescription drug requires a coverage review for approval; contact the PBM. If coverage is approved, the Plan's Copay for a for a 90-day supply of a non-preferred brand name drug will apply.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician or other licensed prescriber that require a prescription either by federal or state law, but excludes any drugs stated as not covered under this Plan.
(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
(3) Insulin and other diabetic supplies (except Glucowatch) when prescribed by a Physician.
(4) Needles and syringes.

(5) Self-administered injectables (specialty drugs require pre-authorization).
(6) Tretinoin topical (e.g., Retin-A, Avita) obtainable by prescription and for persons through the age of 25 years.
(7) Yohimbe and other impotency medications such as Viagra, which are subject to quantity limitations.
(8) Relenza/Tamiflu (retail Pharmacy only).
(9) Ostomy supplies.
(10) Inhaler-assisting devices.
(11) PKU (phenylketonuria) formulas when ordered, in writing, by a Physician or other licensed healthcare provider legally authorized to prescribe drugs.
(12) The Plan will comply within one year of the effective date of all new recommendations or guideline changes as required under the federal Patient Protection and Affordable Care Act; the Plan will not cover any item or service that is no longer a recommended preventive service. No patient cost share is required for generic drugs mandated as covered under this provision. If a generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the brand name drug will be available at no cost share, subject to reasonable medical management approval by the PBM. Please see www.HealthCare.gov/center/regulations/prevention.html for complete listing unless listed below.

Contraceptives FDA-approved when prescribed by a Physician for females with reproductive capacity to include oral contraceptives, contraceptive patches, Nuva Ring, Seasonale (up to a 91-day supply), injectable contraceptives, diaphragms, caps, kits, barrier methods, and emergency contraceptives (retail only). Benefits are not provided for abortifacient drugs.

Tobacco use cessation agents when prescribed by a Physician for Covered Persons over age 18 for over-the-counter and prescription forms to include gum, lozenge, patch, inhaler, nasal spray, and oral agents. Two individual tobacco cessation attempts (180 days) per calendar year will be covered.

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.
(2) Refills up to one year from the date of order by a Physician.
(3) Quantity limits that could apply to controlled substances based on state regulations.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) Administration. Any charge for the administration of any Prescription Drug.
(2) Allergy Serum.
(3) Blood or blood plasma products.
(4) Contraceptive Drugs and devices which are non-systemic, except as required under federal law.
(5) Consumed on Premises. Any drug or medicine that is consumed or administered at the place where it is dispensed. Exception: approved immunizations.
(6) Dental Fluoride Products except pediatric fluoride vitamin drops (retail Pharmacy only; quantity limits apply) and as required under federal law.
(7) **Devices**. Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. Exception: Inhaler assisting devices are covered.
(8) **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes only, such as Retin A as an anti-wrinkle agent or medications for hair growth or removal.
(9) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person, except as required by federal law.
(10**) FDA.** Any drug not approved by the Food and Drug Administration.

(11) **Injectable Drugs.** A charge for injectable drugs not specified as covered.
(12**) Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use."
(14) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.
(15) **No Charge.** A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
(16) **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to a drug or medication covered under federal law.
(17) **Non-legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
(19) **Second Line Drugs.** Prescriptions listed as non-covered "second line drugs" as described above in Preferred Drug Step Therapy Program.

HEARING AID BENEFITS

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

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

UnitedHealthcare Hearing offers:

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

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered and fitted by the provider.

In the event that You have questions about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

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

COVERED BENEFITS

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

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

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

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

ADDITIONAL PROVISIONS AND BENEFITS

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

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

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

COVERED BENEFITS

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

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

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

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

ADDITIONAL PROVISIONS AND BENEFITS

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

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

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

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

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

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

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

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

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

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

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

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

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

SERVICES REQUIRING PRIOR AUTHORIZATION

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

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500.
- Prosthetics over $1,000.
- Qualifying Clinical Trials.
- Chemotherapy performed in a facility (not required in office setting).
- Dialysis.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit Specialty Injectable | UMR for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- Insulin Infusion Devices.
- Autism Spectrum Disorder Services, including Applied Behavior Analysis.
- Oral Surgery.
- MRIs, MRAs, PET scans, CT scans.

- Gender Dysphoria Treatment.
- Inter-facility ambulance transfers.
- TMJ Surgical/Nonsurgical Medical Procedures and Orthognathic, Prognathic and Maxillofacial Surgery.
- Outpatient facility surgery.
- Intensive Outpatient Programs (IOP).
- Short-term rehabilitation – PT/OT/ST.
- Advanced Infertility Services and Genetic Testing related to Infertility.
- Aquatic Therapy.

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount a Covered Person may be required to pay if an authorization has not been completed prior to receiving certain services or prior to admissions as defined in this section. A penalty of $200 may be applied if a Covered Person receives services but does not obtain the required Prior Authorization.

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

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

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

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

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

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

CARE PROVISIONS

Complex Condition CARE

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

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.
- management of catastrophic and complex behavioral health and substance use disorders and support for identified members utilizing Inpatient/rehabilitation/residential facilities.

Cancer Support Program

Plan enrollees who are newly diagnosed with cancer or who are undergoing cancer treatment have the option to enroll in the Cancer Support Program (CSP) sponsored by UMR. Enrollment in the Cancer Support Program is voluntary and at no additional charge, as long as the member is in active treatment and not receiving surveillance care.

Enrollment entitles members to additional benefits and services such as support services and care coordination from a nurse advocate, access to the Transplant Centers of Excellence network, cancer-related information and patient education.

Further, this program utilizes in-network providers only. If enrolled in the CPS Program, Co-payments will be waived for covered services provided by in- network providers.

If a Covered Person wishes to participate in the CSP program, the Covered Person must contact UMR Case Management at 866-494-4502.

Further, if enrolled in the CPS Program, copayments will be waived for covered services provided by in-network providers.

CENTERS OF EXCELLENCE

Optum Cancer Resource Services (CRS)

Cancer Resource Services (CRS) consists of Optum Centers of Excellence (COE) network access while UMR CARE provides critical treatment options and support to members newly diagnosed with rare or complex cancers. This includes direct access to specialized and experienced oncology CARE nurse managers who help members understand their diagnoses and make informed decisions about second opinions, treatment options (including the availability of clinical trials), and preferred treatment facilities.

If a Covered Person chooses to seek services at Roswell Park Cancer Institute, the Covered Person must contact UMR CARE at 866-494-4502 or services will be considered out-of-network.

If a Covered Person chooses to seek services at Huntsman Cancer Institute at the University of Utah in Salt Lake City, the Covered Person must contact UMR CARE at 866-494-4502 or services will be considered out-of-network.

Kidney Resource Services (KRS)

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

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

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

COORDINATION OF BENEFITS

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

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

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

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE

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

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

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

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

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as primary payer.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C; Part A services, the Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

If Medicare is primary for an eligible person and they receive service from a provider that does not participate with Medicare, the Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

TRICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

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

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL EXCLUSIONS

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

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

1. **Abdominoplasty.**

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

3. **Acupuncture Treatment.**

4. **Alternative / Complementary.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.

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

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

7. **Assistant Surgeon Services**, unless determined to be Medically Necessary by the Plan.

8. **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory no-fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the no-fault auto insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the no-fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent allowable fees would have otherwise been payable by this Plan. **Note:** No-Fault and motor vehicle liability coverage is considered another plan under the coordination of benefits provision of this Plan.

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

10. **Blood Pressure Cuffs / Monitors.**

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

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

13. **Claims** received later than 90 days (by March 31) after the end of the calendar year in which the Covered Expense were Incurred.

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

15. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan.

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

17. **Custom-Molded Shoe Inserts,** including the exam for required Prescription and fitting.

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

19. **Developmental Delays**: Medical charges and occupational, physical, or speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy. Services and supplies that any school system is required to provide under any law; this applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

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

21. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.

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

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

24. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act.

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

    Life-Threatening Disease or Condition exception - subject to medical review, an Investigational, Experimental or Unproven drug, supply care, treatment or service may be considered eligible for coverage in the event of a Life-Threatening Disease or Condition (one that is likely to cause death within one year of the request for treatment). See Covered Benefits of this SPD for details.

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

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

28. **Financial Counseling**.

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

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

31. **Genetic Testing,** unless covered elsewhere in this SPD.

32. **Growth Hormones,** unless covered under the Prescription Drug Benefits.

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

34. **Illegal Acts:** Charges for services received as a result of Injury or Illness occurring directly or indirectly as a result of participation in a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

35. **Infertility Treatment:**

    - Surgical reversal of a sterilized state that was a result of a previous surgery.

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

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

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

38. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for the primary diagnosis of a Learning Disability. If another medical or behavioral/mental health condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions. Services and supplies that any school system is required to provide under any law; this applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

39. **Liposuction,** regardless of purpose.

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

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

42. **Marriage Counseling.**

43. **Massage Therapy.**

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

45. **Medical and/or Routine Services Provided in a Foreign Country; Including- Preventive Care or Elective Treatment,** except for services that are Incurred in the event of an Emergency.

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

47. **Nocturnal Enuresis Alarm.**

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

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

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

51. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

52. **Nutrition Counseling,** unless covered elsewhere in this SPD. This exclusion does not apply to preventive care for which benefits are provided under the United States Preventive Task Force requirement. This exclusion also does not apply to medical or behavioral/mental health-related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is part of treatment.
    - There is a lack of knowledge regarding the disease resulting in the need for help from a trained professional.

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

54. **Occupational:** Care and treatment of an Injury or Illness that is occupational, that is, arises from work for wage or profit including self-employment. Payment will not be made even if You or Your Dependents do not claim the entitled benefits.

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

56. **Palliative Foot Care.**

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

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

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

60. **Private Duty Nursing Services.**

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

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

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

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

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

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

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

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

69. **Sex Therapy.**

70. **Sexual Function:** Prescription drugs (unless covered under the Prescription Drug Benefits) in connection with treatment for male or female impotence.

71. **Standby Surgeon Charges.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

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

Pre-Determination

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

TYPE OF CLAIMS AND DEFINITIONS

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

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

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

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

PERSONAL REPRESENTATIVE

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

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

PROCEDURES FOR SUBMITTING CLAIMS

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

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

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

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

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than March 31 after the end of the Calendar Year in which the Covered Expense were Incurred. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim.

Claims received after the timely filing period will not be allowed.

This time limit may also be extended when this Plan is secondary and UMR receives the claim within 90 days after the date of the other plan's or policy's explanation or denial. However, this extension will not apply if the other Plan denies the claim for late submission based on their late filing time limit.

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

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

HOW HEALTH BENEFITS ARE CALCULATED

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

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

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

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

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

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

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

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

NOTIFICATION OF BENEFIT DETERMINATION

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

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

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

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

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

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

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

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

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

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.

- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified only by specialty upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

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

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

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

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

Note: Post-Service Appeal Request forms are available at www.UMR.com to assist you in providing all the recommended information to ensure a full and fair review of your adverse benefit determination. You are not required to use this form.

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

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

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

Send Pharmacy appeals to:
PROACT
6333 ROUTE 298 STE 210
EAST SYRACUSE NY 13057

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

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

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

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

RIGHT TO EXTERNAL REVIEW

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment request involved an intentional misrepresentation of a fact or the services provided were known to the Covered Person to be part of a pattern of fraud and/or abuse.

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

FRAUD

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

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

Each Covered Person must:

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

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

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

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

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (i.e., Your Physician, nurse, midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers 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 precertification. For information on precertification, contact the claims administrator.

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

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

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

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

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

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

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

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

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

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

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

Consortium Employer and Benefits

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan Sponsor means Your Consortium Employer.

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

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

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

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

PLAN AMENDMENT AND TERMINATION INFORMATION

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

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

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

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

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

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

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

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

NO CONTRACT OF EMPLOYMENT

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

GLOSSARY OF TERMS

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

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

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

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

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

Alternative / Complementary Treatment means:

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

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A cochlear implant is not considered Durable Medical Equipment.

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

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

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

Enrollment Date means:

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

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

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

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

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

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

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

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

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

Diagnostic criteria for adults and adolescents:

- A marked incongruence exists between one's experienced/expressed gender and one's 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 must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion 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 must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

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

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

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

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

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

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

Hospital means a facility that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental Health Disorder means any disease or condition within the mental health or psychiatric diagnostic categories 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 the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

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

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

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

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

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

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

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

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

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

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

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

Plan means the MEBCO Health Benefit Plan.

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

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

Prescription means any order authorized by a medical professional for the preparation and administration of a drug, device or supply intended for the person for whom it is prescribed.

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

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

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

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

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

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

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

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

The amount is based on either:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You / Your means the Employee.