SUMMARY PLAN DESCRIPTION

Arizona State Retirement System (ASRS) Medical Choice Premier Non-Medicare Plan with UnitedHealthcare Premium Designation

Effective: January 1, 2026

Group Number: 925164

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Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Health Care Services available to you under the Arizona State Retirement System (ASRS) ("Plan Sponsor") Self-Funded health benefit plan. This *SPD* is a legal document that describes Benefits for the portion of the Plan for which United Healthcare Services, Inc. ("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD*, the Plan includes:

- The *Schedule of Benefits.*
- Amendments.
- Addendums.
- Summary Material Modifications (SMM).

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, Amendment, Addendums or SMMs.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

On its effective date, this *SPD* replaces and overrules any *SPD* that the Plan Sponsor may have previously issued to you. This *SPD* will in turn be overruled by any *SPD* issued to you in the future.

Introduction to Your SPD

This *SPD* and the other Plan documents describe your Benefits, as well as your rights and responsibilities, under the Plan.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *SPD* and any attached Amendments, Addendums or SMMs. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *SPD* at www.myuhc.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as a Participant or a Dependent as those terms are defined in *Section 9: Defined Terms.*

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card

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

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. Benefits for that particular condition or disability are subject to your prior coverage.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

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

Plan Sponsor and the Claims Administrator have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and any SMMs and/or Amendments.
- Make factual determinations relating to Benefits.

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

The Plan Sponsor’s decisions shall receive judicial deference to the extent they are not arbitrary and capricious.

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

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

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

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

The Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See *Section 5: How to File a Claim.*

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

The Claims Administrator adjudicates claims consistent with industry standards. The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, generally in accordance with one or more of the following methodologies:

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

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

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

Offer Health Education Services to You

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

UnitedHealthcare Choice

United Healthcare Services, Inc.

Schedule of Benefits

How Do You Access Benefits?

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits,* Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Benefits.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

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

Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Ground Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits.*

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

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

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

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

Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis. Out-of-Pocket Limits are calculated on a calendar year basis.

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term and Description Table

Payment Term And Description	Amounts
	The Amount You Pay **Designated Network and Network**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible. Any amount that you pay for Covered Health Care Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Care Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.	**Designated Network and Network** $500 per Covered Person, not to exceed $1,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
	The Amount You Pay **Designated Network and Network**
Per Occurrence Deductible	
The amount stated as a set dollar amount that you must pay for certain Covered Health Care Services (prior to and in addition to any Annual Deductible) before the Claims Administrator will begin processing payment on behalf of the Plan for Benefits for those Covered Health Care Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Allowed Amount or the Recognized Amount when applicable.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Care Service category.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. Any amount that you pay for Covered Health Care Services that is applied to the Designated Network Out-of-Pocket Limit will be applied to the Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services that is applied to the Network Out-of-Pocket Limit will be applied to the Designated Network Out-of-Pocket Limit. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	**Designated Network and Network** $4,000 per Covered Person, not to exceed $8,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible.

Payment Term And Description	Amounts
	The Amount You Pay **Designated Network and Network**
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in *Section 9: Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**What are the Limitations & Exceptions?**
Ambulance Services		
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation.		
Emergency Ambulance Ground, water or Air Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* None *Air Ambulance:* None *Water Ambulance* None	Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*. In general, you cannot be balance billed for Air Ambulance items or services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* No *Air Ambulance:* No *Water Ambulance* No	
Does the Annual Deductible Apply?	*Ground Ambulance:* No *Air Ambulance:* No *Water Ambulance* No	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Non-Emergency Ambulance Ground, water or Air Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* None *Air Ambulance:* None *Water Ambulance* None	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* No *Air Ambulance:* No *Water Ambulance* No	
Does the Annual Deductible Apply?	*Ground Ambulance:* No *Air Ambulance:* No *Water Ambulance* No	
Cellular and Gene Therapy		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury* in this *Schedule of Benefits*.	Cellular or Gene Therapy services must be received from a Designated Provider.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Clinical Trials		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury* in this *Schedule of Benefits.*	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.
Congenital Heart Disease (CHD) Surgeries		
It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes,	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Dental Services - Accident Only		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
		limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years. You must obtain the DME from the vendor the Claims Administrator identifies or from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Emergency Health Care Services - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$300 per visit	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
		under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Enteral Nutrition		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Gender Dysphoria		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated *Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or Reconstructive Procedures* in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services* in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$40 per visit *Spinal Manipulation* $100 per visit	Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. • ABA therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*. **Note:** Visit limits will not apply to Medically Necessary ABA, physical, occupational, speech and cognitive rehabilitation therapies for treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Hearing Aids		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Benefits are limited to a single purchase per hearing impaired ear every year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Home Health Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Hospice Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Hospital - Inpatient Stay		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes,	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding lab* $10 per service at a freestanding lab or in a Physician's office *Hospital-based lab* $30 per service at a Hospital-based lab	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab or in a Physician's office* Yes *Hospital-based lab* Yes	
Does the Annual Deductible Apply?	*Freestanding lab or in a Physician's office* No *Hospital-based lab* No	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center or in a Physician's office* $10 per service at a freestanding diagnostic center or in a Physician's office	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	Outpatient Hospital-based diagnostic center $30 per service at a Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding diagnostic center or in a Physician's office* Yes *Outpatient Hospital-based diagnostic center* Yes	
Does the Annual Deductible Apply?	*Freestanding diagnostic center or in a Physician's office* No *Outpatient Hospital-based diagnostic center* No	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center or in a Physician's office* $150 per service at a freestanding diagnostic center or in a Physician's office *Outpatient Hospital-based diagnostic center* $250 per service at a Hospital-based diagnostic center	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding diagnostic center or in a Physician's office* Yes *Outpatient Hospital-based diagnostic center* Yes	
Does the Annual Deductible Apply?	*Freestanding diagnostic center or in a Physician's office* No *Outpatient Hospital-based diagnostic center* No	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Office Visits* $20 per visit *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 30% *Intensive Behavioral Therapy* $20 per visit	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Office Visits* Yes *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* Yes	
Does the Annual Deductible Apply	*Office Visits* No, after the Per Occurrence Deductible of $100 per Inpatient Stay is Satisfied *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* Yes *Intensive Behavioral Therapy* No	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *AbleTo Therapy 360* None	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	No	
Non-Preventive Nutritional Counseling		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow m**ental health and substance-related and addictive disorders services** office visit.	
Ostomy Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Pharmaceutical Products - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Allowed Amounts for Covered Health Care Services provided by an out-of-Network facility based Physician in a Network facility will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	
Physician Fees for Surgical and Medical Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Outpatient Hospital-based surgical center* 40% at an outpatient Hospital-based surgical center *All other places of service* 30%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Physician's Office Services - Sickness and Injury		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	**Designated Network** $20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit **Network** $40 per visit for a Primary Care Physician office visit or $100 per visit for a Specialist office visit None for allergy injections when no other service is provided during the office visit	Copayment/ Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures -*

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
		Outpatient Diagnostic and Therapeutic. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Pregnancy - Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
The coverage for birth costs for an adopted child under this Plan is secondary to any coverage for maternity-related expenses that the birth mother may have and Benefits will be coordinated as described in *Section 7: Coordination of Benefits*.	Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury* in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preventive Care Services		
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	No	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit? Does the Annual Deductible Apply?	No No	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Prosthetic Devices		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury and Prosthetic Devices* in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$40 per visit *Spinal Manipulation* $100 per visit	Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. **Note:** Visit limits will not apply to Medically Necessary physical, occupational, speech and cognitive rehabilitation therapies for treatment of diagnosed Mental Illness or Substance-Related and Addictive Disorders consistent with generally recognized independent standards of current medical practice.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding center* or in a Physician's office 30% at a freestanding center or in a Physician's office *Outpatient Hospital-based center* 40% at an outpatient Hospital-based center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding center* at a freestanding center or in a Physician's office Yes *Outpatient Hospital-based center* *Yes*	
Does the Annual Deductible Apply?	*Freestanding center* at a freestanding center or in a Physician's office Yes *Outpatient Hospital-based center* Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Limited to 60 days per year. **Note**: Day limits will not apply to Medically Necessary inpatient rehabilitation services for treatment of diagnosed Mental Illness or Substance-Related and Addictive Disorders consistent with generally recognized independent standards of current medical practice.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Surgery - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ambulatory surgical center or in a Physician's office* 30% at an ambulatory surgical center or in a Physician's office *Outpatient Hospital-based surgical center* 40% at an outpatient Hospital-based surgical center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	
Does the Annual Deductible Apply?	*Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based center surgical center* Yes	
Therapeutic Treatments - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Yes	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury and Surgery - Outpatient* in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$50 per visit	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Urinary Catheters		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Virtual Care Services		
What Is the Copayment or Coinsurance You Pay? This	None	Benefits are available only when services are delivered through a Designated Virtual Network

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
May Include a Copayment, Coinsurance or Both.		Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Vision Exams		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit	Limited to 1 exam every 24 months.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Wigs		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Limited to 1 item every 36 months. Replacements are limited to a single purchase of a type of wig or other scalp hair prostheses every three years.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Additional Benefits Required By Arizona Law		
Manipulative Treatment		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per visit	Limited to 20 Manipulative Treatments per year
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	No	
Off-Label Drugs for the Treatment of Cancer or for a Mental Illness or Substance-Related and Addictive Disorders diagnosis	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Pharmaceutical Products - Outpatient and Physician Office Services – Sickness and Injury* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug* in this *Schedule of Benefits*.	
Orthognathic Surgery	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury and Surgery - Outpatient* in this *Schedule of Benefits*.	
Telemedicine	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Lab, X-Ray and Diagnostics – Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Office Services – Sickness and Injury* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug* in this *Schedule of Benefits.*	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria 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 Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.

- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.
- Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

For Designated Network Benefits and Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Network provider, Allowed Amounts are the Claims Administrators contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

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 Health Service Act* with respect to a visit as defined by the Secretary (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 below 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, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by 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 Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by 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 Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan. The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Allowed Amount (which includes your Coinsurance, Copayment, and deductible) is yours.

- **For Emergency ground ambulance transportation provided by an out-of-Network provider,** the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to out-of-network providers that have questions about the Allowed Amounts and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Allowed Amount, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Allowed Amount for that particular claim.

Travel and Lodging (For Travel and Lodging related to complex medical conditions see *Clinical Programs and Resources*).

The Plan provides a Covered Person, provided that the Covered Person is not covered by Medicare, with a travel and lodging allowance related to the Covered Health Care Service, including for Mental Health Care and Substance-Related and Addictive Disorders Services provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such services are received in another state, as legally permissible.
The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Care Services. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.
This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to a maximum lifetime allowance of $10,000 per Covered Person during the entire period of time a Covered Person is enrolled under the Plan will be provided for travel and lodging expenses incurred as a part of the Covered Health Care Service. Lodging expenses are further limited to $50 per day for the Covered Person, or $100 per day for the Covered Person with a travel companion. When a child is the Covered Person, two persons may accompany the child.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at **www.myuhc.com** or the telephone number on your ID card.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not Arizona State Retirement System (ASRS)'s or the Claims Administrator's employees. It is your responsibility to choose your provider.

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

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

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

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of

care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

Designated Providers

If you have a medical condition (including Mental Illness or Substance-Related and Addictive Disorders diagnosis) that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Care Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, the Plan may reimburse certain travel expenses. In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

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

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

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

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

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

Outpatient Facility Charges: Benefits are available for the facility charge and related charge for supplies and equipment for Covered Health Care Services. Depending upon where the Covered Health Care Service is provided, Benefits for outpatient facility charges will be the same as those stated under each Covered Health Care Service category in the *Schedule of Benefits.*

Ambulance Services

Emergency ambulance services, without prior authorization, to the nearest Hospital or other facility that is licensed or otherwise authorized to furnish Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

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

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

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

- Ambulance" means any publicly or privately owned surface, water or air vehicle, including a helicopter, that contains a stretcher and necessary medical equipment and supplies pursuant to Arizona Revised Statutes Section 36-2202 and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. Ambulance does not include a surface vehicle that is owned and operated by a private sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in-transit care of its employees or a vehicle that is operated to accommodate an incapacitated person or person with a disability who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or ambulance attendants.
- "Emergency ambulance services" means services provided by an Ambulance service authorized to operate pursuant to Arizona Revised Statutes Title 36, Chapter 21.1 following the onset of a medical condition that manifests itself by symptoms of pain, illness, or Injury that the absence of accessing an ambulance or emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:
  - Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.
- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

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

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

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
    - Certain *Category B* devices.
    - Certain promising interventions for patients with terminal illnesses.
    - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
    - *Centers for Disease Control and Prevention (CDC)*.
    - *Agency for Healthcare Research and Quality (AHRQ)*.
    - *Centers for Medicare and Medicaid Services (CMS)*.
    - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
    - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
    - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
        - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
        - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.
- With respect to a clinical trial for the treatment of cancer, the personnel providing the treatment or conducting the study are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training, and volume of patients treated to maintain expertise.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

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

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

Dental services to repair damage caused by accidental Injury must follow these time-frames:

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

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

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.

- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits for diabetes self-management training include training, after the initial diagnosis, in the care and management of diabetes, including proper use of diabetes equipment and supplies.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes.

Benefits are available for therapeutic shoes for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history or pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits diabetic supplies for blood glucose meters, including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Plan* and include the following:

- Blood glucose monitors.
- Blood glucose monitors for the legally blind.
- Test strips for glucose monitors and visual reading and urine testing strips.
- Insulin preparations and glucagon.
- Insulin cartridges.
- Drawing up devices and monitors for the visually impaired.
- Injection aids.
- Insulin cartridges for the legally blind.
- Syringes and lancets, including automatic lancing devices.
- Prescribed oral agents for controlling blood sugar.
- Any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

Durable Medical Equipment (DME), Orthotics and Supplies

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

DME and Supplies

Examples of DME and supplies include:

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

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

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

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

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

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

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

Emergency Health Care Services - Outpatient

A screening examination and services that are required to stabilize or begin treatment in an Emergency including the assessment and stabilization of a psychiatric emergency medical condition. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Care Services do not require prior authorization.

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

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

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Gender Dysphoria

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

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

Habilitative Services

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

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.
- ABA therapy.

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

- Treatment is administered by any of the following:
    - Licensed speech-language pathologist.
    - Licensed audiologist.
    - Licensed occupational therapist.
    - Licensed physical therapist.
    - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.

- Therapeutic recreation.
- Educational/vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Medical records.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress the Claims Administrator may request additional medical records.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

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

Hearing Aids

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

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *SPD*. They are only available if you have either of the following:

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

Home Health Care

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

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

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

Hospice Care

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

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

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

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

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

Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

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

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

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

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

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, Brain Electrical Activity Mapping (BEAM), Electroconvulsive therapy (ECT), nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include:

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

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

Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

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

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

- Psychiatric Service.
- Detoxification.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis* (*ABA*)) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. (“AbleTo Therapy360 Program”) for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Non-Preventive Nutritional Counseling

Non-preventive nutritional counseling services for mental health and substance-related and addictive disorders and medical diagnosis that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals.

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

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

Pharmaceutical Products - Outpatient

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

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

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

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

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

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

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals.

Benefits include nutritional evaluation and counseling provided by a Physician when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to morbid obesity, diabetes, cardiovascular disease, hypertension, kidney disease, eating disorders, gastrointestinal disorders, food allergies and hyperlipidemia.

Covered Health Care Services include outpatient contraceptive services, which include consultations, examinations, procedures and medical services related to the use of United States *Food and Drug Administration* (FDA) approved prescription contraceptive methods to prevent unintended pregnancies.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections and antigen administration. Benefits for allergy testing are provided under *Lab, X-Ray and Diagnostics - Outpatient*.

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

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

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

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

The Claims Administrator also has special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify the Claims Administrator regarding your Pregnancy.

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

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Benefits are available for maternity-related medical, Hospital and other Covered Health Care Services for the birth of any child legally adopted by the Subscriber if all of the following are true:

- The child is adopted within one year of birth.
- The Subscriber is legally obligated to pay the costs of birth.
- The Subscriber has notified us of his or her acceptability to adopt children within 60 days after approval is received or within 60 days after a change in health care coverage.

This coverage is secondary to any coverage for maternity-related expenses that the birth mother may have and Benefits will be coordinated as described in *Section 7: Coordination of Benefits*.

Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions.
- 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*. Benefits include:
    - Screening newborns for hearing problems, thyroid disease, phenylketonuria, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.

- For children: Counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders; counseling for obesity.
- Well child visits and immunizations are covered through 47 months as recommended by the *American Academy of Pediatrics*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include PSA screenings. Preventive screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Forc*e are described under *Preventive Care Services*. Benefits include:
  - Preventive care visits to include preconception and prenatal services.
  - Voluntary family planning and contraceptive services, which include, but are not limited to the following services:
    - Office visits and examinations (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
    - Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).
    - Contraceptive device fittings, insertions and removals (e.g., IUDs, diaphragms, cervical caps).
    - Female sterilization methods, including surgical sterilization (tubal ligation) and implantable sterilization (e.g. Essure).
  - Breastfeeding support and counseling, includes lactation support counseling during pregnancy and/or in the post-partum period.
  - Human papillomavirus (HPV) DNA testing for women 30 years and older.
  - Domestic violence screening and counseling.
  - Annual human immunodeficiency virus (HIV) screening and counseling.
  - Annual sexually-transmitted infection counseling.
  - Screening for gestational diabetes for all pregnant women that have not prior history of diabetes.
  - Genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing.
  - Osteoporosis screening.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:
  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.

Benefits for screening mammography are provided, at a minimum, according to the following guidelines:

- A single baseline mammogram for a woman age 35 through 39.
- A mammogram every year for a woman age 40 and older.
- Non-routine mammograms will be covered more frequently based on the recommendation of the woman's Physician.

- With respect to all at an appropriate age and/or risk status, Benefits include:
  - Counseling and/or screening for: colorectal cancer, elevated cholesterol and lipids; sexually transmitted diseases; human immunodeficiency virus (HIV); depression; high blood pressure; diabetes; Preventive Care Medications.
  - Screening and counseling for alcohol abuse in a primary care setting; obesity; diet and nutrition.
  - Behavioral counseling to prevent skin cancer for ages 10 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Benefits for Preventive Care Medications are provided as described under the *Outpatient Prescription Drug Rider*.

You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at **www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm** and the women's preventive services at **www.hrsa.gov/womensguidelines/** If you do not have internet access, please call us at the telephone number on your ID card.

Prosthetic Devices

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

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

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

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

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

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance except for reconstructive procedures following a mastectomy as required by the *Women's Health and Cancer Rights Act of 1998*.

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications (including lymphedemas), are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

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

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

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

Benefits are not available for maintenance/preventive treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

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

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

Surgery - Outpatient

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

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

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.

- Hysteroscopy.

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

Benefits include:

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

Therapeutic Treatments - Outpatient

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

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

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals.

Benefits include:

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

Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

- Cornea.

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

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

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

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

Urinary Catheters

Benefits are provided for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

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

Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

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

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Exams

Routine vision exams received from a health care provider in the provider's office. Routine vision exams include refraction to find vision impairment.

Benefits for eye exams required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury.*

Wigs

Wigs and other scalp hair prostheses regardless of the reason for hair loss.

Additional Benefits Required By Arizona Law

Manipulative Treatment

Benefits for Manipulative Treatment must be performed by a Network chiropractic provider for a minimum of 20 self-referred visits per year. Please refer to the *Schedule of Benefits* to determine the exact number of covered visits per year your Benefit plan offers.

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

- You are not progressing in goal-directed Manipulative Treatment.
- Treatment goals have previously been met.

Benefits are not available for maintenance/preventive Manipulative Treatment.

Off-Label Drugs for the Treatment of Cancer (or for Medically Necessary Treatment of a Mental Health or Substance-Related and Addictive Disorders)

Benefits are available for drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer (or treatment of a severe Mental Health or Substance-Related and Addictive Disorders diagnosis) in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:

- The acceptable standard medical reference compendia are the following:
  - The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.
  - The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.
  - *Thomson Micromedex Compendium DRUGDEX*.
  - *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
  - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
- Medical literature may be accepted if all of the following apply:
  - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
  - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety

and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

- The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).

Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are provided when determined to be Medically Necessary.

Telemedicine

Benefits are available for health care services received through telemedicine if the health care service would be covered were it provided through in-person consultation between you and a health care provider and provided to you while receiving the Covered Health Care Service in the State of Arizona. Health care services appropriately provided through telemedicine are subject to all terms and conditions of the Policy.

Health care services provided through telemedicine or resulting from a telemedicine consultation must comply with Arizona license requirements, accreditation standards and any practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

For the purpose of this Benefit:

- "Telemedicine" means the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.
- "Health care services" means services provided for the following conditions or in the following situations:
  - Trauma.
  - Burn.
  - Cardiology.
  - Infectious diseases.
  - Mental Health Care Services.
  - Neurologic diseases including strokes.
  - Dermatology.
  - Pulmonology.
  - Pain Medicine
  - Substance Abuse

Section 2: Exclusions and Limitations

How Are Headings Used in this Section?

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

Plan Does Not Pay Benefits for Exclusions

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

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

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

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

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

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

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

4. Dental braces (orthodontics).

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

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.

- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

5. Oral appliances for snoring.

6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.

8. Powered and non-powered exoskeleton devices.

9. Over-the-counter continuous glucose monitors.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to diabetic prescription medications as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion. This exclusion does not apply to diabetic prescription medications as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.

4. Over-the-counter drugs and treatments. This exclusion does not apply to:

   - Aspirin for which Benefits are available as recommended by the *United States Preventive Task Force* as a preventive care service.

   - Counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.

   - All other *United States Preventive Services Task Force "*A" and "B" recommended over-the-counter medications and supplements when prescribed by a Network provider. You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at **http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations**.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator’s designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness

or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Plan*. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Plan*. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Plan*. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Plan*, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.

11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

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

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

Foot Care

1. Routine foot care. Examples include:

- Cutting or removal of corns and calluses.
- Nail trimming, nail cutting, or nail debridement.
- Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts
7. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:
    - Abdominoplasty.
    - Blepharoplasty.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.
    - Hair removal, except as part of a genital reconstruction procedure by a physician for the treatment of gender Dysphoria.
    - Hair transplantation.
    - Lip augmentation.
    - Lip reduction.
    - Liposuction.
    - Mastopexy.
    - Pectoral implants for chest masculinization.
    - Rhinoplasty.
    - Skin resurfacing.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
    - Compression stockings.
    - Ace bandages.
    - Gauze and dressings.

    This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.
- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*
- Urinary catheters and related urologic supplies for which Benefits are provided as described under Urinary Catheters in *Section 1: Covered Health Care Services*.

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Nutrition

1. Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force or to Benefits provided under Non-Preventive Nutritional Counseling as described in Section 1, Covered Health Care Services.2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk. This exclusion does not apply to enteral feedings required for the treatment of Inherited Metabolic Disorder or for Medically Necessary treatment of an eating disorder for which Benefits are provided as described in the *Outpatient Prescription Drug Rider*. See the Benefits for medical foods described under the *Outpatient Prescription Drug Rider*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. See the Benefits for eosinophilic gastrointestinal disorder formula described under the *Outpatient Prescription Drug Rider*.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.

- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:

   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.

- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 1: *Covered Health Care Services*.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Sclerotherapy treatment of veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.
6. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
7. Biofeedback.
8. Services for the evaluation and treatment of TMJ, whether the services are considered to be medical or dental in nature. This exclusion does not apply to orthognathic surgery for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Care Services*.
9. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment. This exclusion does not apply to orthognathic surgery for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Care Services*.
10. Surgical and non-surgical treatment of obesity.

11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

12. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*. This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.

13. Helicobacter pylori (H. pylori) serologic testing.

14. Intracellular micronutrient testing.

15. Cellular and Gene Therapy services not received from a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

    - Has not been involved in your medical care prior to ordering the service, or
    - Is not involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

    - Fees for the use of a Gestational Carrier or Surrogate.
    - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to a Gestational Carrier.
    - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.

4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

    - Known egg donor (altruistic donation i.e. friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
    - Purchased egg donor (i.e. clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has

already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.

- Known donor sperm (altruistic donation i.e. friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
- Purchased donor sperm (i.e. clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
6. The reversal of voluntary sterilization.
7. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.

Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services. This exclusion does not apply to the following:

- Preauthorized Covered Health Care Services from a Designated Provider that require you to travel outside of the Service Area.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Care Services described below* in *Clinical Programs and Resources.* Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back at the Claims Administrator' discretion.

3. Travel expenses for which Benefits are provided when you receive a Covered Health Care Service from an out-of-Network provider as a result of an Emergency or if we refer you to an out-of-Network provider. We will reimburse the out-of-Network provider for any out-of-Network cost that you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider.

Types of Care, Supportive Services, and Housing

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing Inpatient.

5. Private Duty Nursing Outpatient.

6. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.

7. Rest cures.

8. Services of personal care aides.

9. Independent living services.

10. Assisted living services.

11. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individual with Disabilities Education Act*.

12. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).

13. Transitional Living services (including recovery residences).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.

2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).

3. Eye exercise or vision therapy.

4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

5. Bone anchored hearing aids except when either of the following applies:

- You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Plan.

Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

6. Over-the-counter hearing aids.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders unless Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.

   Vaccinations and immunizations required as a prerequisite for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, travel, licensure, certification, registration, sports or recreational activities unless such immunizations are also considered preventative care.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.

6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

7. Charges in excess of the Allowed Amount or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

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

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

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

If you do not wish to change your benefit election due to the birth of a newborn, the automatic coverage for the newborn will terminate immediately following day 31 after birth. You will need to wait until the next annual Open Enrollment to change your election if coverage has not been selected within 31 days.

Cost of Coverage

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

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

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

What If You Are Eligible for Medicare?

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

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

The Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For a complete definition of Eligible Person, Plan Sponsor and Participant, see *Section 9: Defined Terms*.

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan and is enrolled in a Arizona State Retirement System (ASRS) Medicare Advantage plan.

Eligible Persons must live within the United States.

Dependent

Dependent generally refers to the Participant's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

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

- Your Spouse.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

The Plan Sponsor sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

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

New Eligible Persons

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

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

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

Special Enrollment Period

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

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

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

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

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

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

  Your coverage ends on the date the Policy ends, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Participant," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- **Participants Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the last day of the calendar month in which the Participant is retired or receiving benefits under the Plan Sponsor 's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Plan, and only if the Participant continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

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

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

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Plan ends will not end automatically. The Plan Sponsor will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Plan ends.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

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

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

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

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

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

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

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 12 months after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, in the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

How Are Outpatient Prescription Drug Benefits Paid?

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

Required Information

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

- The Participant's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.

- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 7: Coordination of Benefits*.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

For medical claims, the appeals address is:

UnitedHealthcare - Appeals

P.O. Box 30432,

Salt Lake City, Utah 84130-0432

Appeal Process

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

Appeals Determinations

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

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

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

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

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

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

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

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

External Review Program

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

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

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- Any adverse benefit determination that involves consideration of whether a plan or issuer is complying with surprise billing and cost- sharing protections under the No Surprises Act.
- As otherwise required by applicable law.

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

An external review request should include all of the following:

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

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

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

Standard External Review

A standard external review includes all of the following:

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

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

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

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

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

Expedited External Review

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

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

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

In addition, you must have filed a request for an expedited internal appeal.

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

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

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

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

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external

review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

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

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

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

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

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

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

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

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

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

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

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

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

How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.

- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

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

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Care Services under this Plan.

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

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

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

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Care Services by following the steps below.

- The Plan determines the amount it would have paid based on the Primary Plan's Allowable Expense.

- If this Plan would have paid less than the Primary Plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

Medicare Crossover Program

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

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

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

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

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

Right to Receive and Release Needed Information?

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

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

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

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

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

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

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

The Plan Sponsor is solely responsible for all of the following:

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

What Is Your Relationship with Providers and Plan Sponsors?

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

You are responsible for all of the following:

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

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

The relationship between you and the Plan Sponsor is that of employer and employee, Dependent or other classification as defined in the Plan.

Notice

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

Statements by the Plan Sponsor or Participants

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

Does the Claims Administrator Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

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

Are Incentives Available to You?

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

Does the Claims Administrator Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

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

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

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

Who Provides Administrative Services?

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

What is the Future of the Plan?

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

The Plan Sponsor's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Plan Sponsor does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

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

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

Amendments to the Plan

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

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

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

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

How Does the Claims Administrator Use Information and Records?

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

- To administer the Plan and pay claims.

- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Claims Administrator may use or disclose your information is found in the Claims Administrator *Notice of Privacy Practices.*

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

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

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

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to the Claims Administrator *Notice of Privacy Practices.*

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

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

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

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

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

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan Sponsor's Plan is the secondary payer as described in *Section 7: Coordination of Benefits,* the Claims Administrator will process the Plan Sponsors payment of Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Sponsor's Plan is the secondary payer, the Claims Administrator will process the Plan Sponsor's payment of any Benefits available to you under the Plan as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

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

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

Subrogation Example:

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

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

Reimbursement Example:

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- 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 which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter

how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile Plan - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing a reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian brings a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the 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 participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plan's 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.

When Does the Plan Receive Refunds of Overpayments?

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

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

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

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

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The *SPD*, the *Schedule of Benefits*, and any Addendums, SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

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

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Allowed Amounts - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator or as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings generally in accordance with one or more of the following methodologies:

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

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

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - the total of the Allowed Amount, or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or the Recognized Amount when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.

Benefits - your right to payment for Covered Health Care Services that are available under the Plan.

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

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

Coinsurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

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

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.

Covered Person - the Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or

maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

Dependent - the Participant's legal spouse or a child of the Participant or the Participant's spouse. As described in *Section 3: When Coverage Begins*, the Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Plan Sponsor is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

The Participant must reimburse the Plan for any Benefits paid during a time a child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

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

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

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and supporting documents. An Eligible Person must live within the United States.

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

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

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C.* 1395dd or as would be required under such section if such section applied to an *Independent Freestanding Emergency Department*) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient’s medical condition.

b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c) The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:
    - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
    - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
    - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
    - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health care Services.
- The Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition if:
    - If you are not a participant in a qualifying Clinical Trial as described under Section 1: Covered Health care Services; and
    - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Care Services.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Programs - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

Manipulative Treatment (adjustment) - the nonsurgical and noninvasive treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice.

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

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion:

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

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

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

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

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

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Delegate - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

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

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

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

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

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product

or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by the Claims Administrator or the Claims Administrator's designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented; or
- December 31st of the following calendar year.

Open Enrollment Period - An annual period, usually occurring shortly before the beginning of a new plan year, during which Eligible Persons can enroll for benefits and change their elections under the Plan. The Open Enrollment Period is effective based on the date agreed upon between the Group and us.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the Plan Sponsor's Self-Funded group health benefit plan.

The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount - the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:.

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

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Remote **Physiologic Monitoring** - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - a program of Mental Health Care Services or Substance-Related and Addictive Disorders Services that meets all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.

  - Evaluation and diagnosis.
  - Counseling.
- Referral and orientation to specialized community resources.

Residential Treatment Facility- a Hospital or facility, licensed and operated as required by law, that provides Residential Treatment.

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Products - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse - an individual to whom you are legally married.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a disorder is listed in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this *SPD.* Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the American Society of Addiction Medicine (ASAM) Criteria and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery. Please note: these living arrangements are also known as supportive housing (including recovery residences).

Unproven Services – health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com** and liveandworkwell.com.

Please note:

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - an entity that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Amendment: Real Appeal

This Amendment to the Plan is issued by the Plan Sponsor as described below.

Because this Amendment is part of a legal document, the Plan wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Plan has defined these words in the *Summary Plan Description* in *Section 9: Defined Terms*.

What is the Real Appeal Amendment?

This Amendment to the Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact the Claims Administrator through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

Clinical Programs and Resources

Care Management

Care Management Solutions

Personal Health Support

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Personal Health Support Nurses will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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

Complex Medical Conditions, Programs and Services

Cancer Resource Services (CRS) Program

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

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program*.

Cancer Support Program

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

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

Congenital Heart Disease (CHD) Resource Services

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

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on your ID card.

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance.*

Kidney Resource Services (KRS) program

End-Stage Renal Disease (ESRD)

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

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

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

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

Transplant Resource Services (TRS) Program

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

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card.

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program*.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Care Services described below.

Your Plan Sponsor may provide you with Travel and Lodging assistance for certain Covered Health Care Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the requisite distance from your home address to the facility is at least 50 miles. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Complex Medical Conditions Travel and Lodging Assistance Program, please call the number on your ID card.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Covered Person and a travel companion, provided the Covered Person is not covered by Medicare as follows:

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

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

Lodging

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

Decision Support

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

This program offers:

- Access health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.

- Coronary disease.

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

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.
    - Use of mail-order pharmacy and Network providers.

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

Wellness Management/Preventive Care

Reminder Programs

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

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.

- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

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

Consumer Solutions and Self-Service Tools

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

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. The Claims Administrator and the Plan Sponsor are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

www.myuhc.com

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

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.

- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

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

UnitedHealth Premium® Designation Program

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate a *Premium Care Physician*, log onto www.myuhc.com or call the number on your ID card.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com for additional information.

Outpatient Prescription Drug Schedule of Benefits

United Healthcare Services, Inc.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate of Coverage*, regardless of tier placement.

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

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

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee. The reason for obtaining prior authorization from the Claims Administrator is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

The Plan may also require you to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee so the Claims Administrator can determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Claims Administrator's review and change. There may be certain Prescription Drug Products that require you to notify the Claims Administrator directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you can ask the Claims Administrator to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Claims Administrator as described in this *Summary Plan Description (SPD)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and the Claims Administrator determines that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

The Claims Administrator may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Outpatient Prescription Drug Plan are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

Benefits for Tier 1 Prescription Drug Products at a Network Pharmacy are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under this Outpatient Prescription Drug Plan will not be included in calculating any Out-of-Pocket Limit stated in this *SPD*:

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

Prescription Drug Product Cost Sharing Accumulation

Any Co-payment, Co-insurance, or other applicable cost sharing requirement for pharmacy Benefits paid by the Covered Person or another person on behalf of the Covered Person will contribute toward the calculation of a Covered Person's Out-of-Pocket Limit and Deductible.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Special Programs:** The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, the Claims Administrator may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** The Claims Administrator may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Copayment and/or Coinsurance.	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? **This May Include a Copayment, Coinsurance or Both**	Description and Supply Limits
Eosinophilic Gastrointestinal Disorder Formula Benefits for Eosinophilic Gastrointestinal Disorder Formula are subject to payment of the Annual Drug Deductible in high deductible health plans only.	You pay 25% of the Prescription Drug Charge per Prescription Order or Refill for Eosinophilic Gastrointestinal Disorder Formula.	
Medical Foods Benefits for Medical Foods are subject to payment of the Annual Drug Deductible in high deductible health plans only.	You pay 50% of the Prescription Drug Charge per Prescription Order or Refill for Medical Foods to treat an Inherited Metabolic Disorder or for Medically Necessary treatment of an eating disorder.	
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $50.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $100.00 per Prescription Order or Refill.	The following supply limits apply. • As written by the provider, up to a consecutive 90-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? **This May Include a Copayment, Coinsurance or Both**	Description and Supply Limits
		and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. Supply limits apply to Specialty Prescription Drug Products obtained at Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? **This May Include a Copayment, Coinsurance or Both**	Description and Supply Limits
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	For a 1-31-day supply at a Retail Network Pharmacy, you pay: For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $50 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $100 per Prescription Order or Refill. For a 32-90-day supply at a Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $20 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $100 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $200 per Prescription Order or Refill	The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. Certain Prescription Drug Products on the List of Vital Medications are available from any retail Network Pharmacy at zero cost

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? **This May Include a Copayment, Coinsurance or Both**	Description and Supply Limits
		share (no cost share to you.) You are not responsible for paying any cost share for Prescription Drug Products on the List of Vital Medications.

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? **This May Include a Copayment, Coinsurance or Both**	Description and Supply Limits
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For a 1-31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $100 per Prescription Order or Refill For a 32-90-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $20 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $100 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $200 per Prescription Order or Refill	You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. Certain Prescription Drug Products on the List of Vital Medications may be available from a mail order Network Pharmacy. You are not responsible for paying any cost share for Prescription Drug Products on the List of Vital Medications

Outpatient Prescription Drug Plan

United Healthcare Services, Inc.

This portion of the Plan provides Benefits for Prescription Drug Products.

Because this section is part of a legal document, the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Claims Administrator has defined these words in either the *Summary Plan Description (SPD)* in *Section 9: Defined Terms* or in this Plan in *Outpatient Prescription Drug Defined Terms*.

When the Plan Sponsor uses the words "you" and "your" the Plan Sponsor is referring to people who are Covered Persons, as the term is defined in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in this *SPD* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Outpatient Prescription Drug Plan. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *SPD*.

Introduction Outpatient Prescription Drug Plan

Coverage Policies and Guidelines

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

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

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

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

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

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from the Plan as described in this *SPD* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager at the address on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

Smart Fill Program - Split Fill

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

When Does the Claims Administrator Limit Selection of Pharmacies?

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

Rebates and Other Payments

The Claims Administrator and Arizona State Retirement System (ASRS) may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by the Claims Administrator, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

The Claims Administrator and a number of its affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Plan*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Plan*. The Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

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

Special Programs

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified

target. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, the Claims Administrator may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy but do not inform the Claims Administrator, no Benefit will be paid.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. You may access information on these procedures through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Benefits for Refills for Prescription Eye Drops to Treat Glaucoma or Ocular Hypertension

Benefits include refills of a prescription for eye drops to treat glaucoma or ocular hypertension if the following apply:

- You request the refill:
  - For a 30-day supply, at least 23 days but not less than 33 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
  - For a 60-day supply, at least 45 days but not less than 60 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
  - For a 90-day supply, at least 68 days but not less than 90 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
- The eye drops to treat glaucoma or ocular hypertension prescribed by the provider are a Covered Health Care Service under the Policy.
- The prescribing provider indicates on the original prescription that additional quantities of the eye drops are needed.
- The refill requested by you does not exceed the number of additional quantities prescribed.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception. Benefits are also available for Preventive Care Medications as defined in *Section 3: Defined Terms* and include, but are not limited to, over-the-counter aspirin in accordance with the current recommendations of the *United States Preventive Services Task Force* and prescribed by a Network provider.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid.

Please see *Outpatient Prescription Drug Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy

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

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy supply limits apply.

Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Variable Copayment Program

Certain Prescription Drug Products, including certain Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. The Claims Administrator may help you determine whether your Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Copayment and/or Coinsurance may vary. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for a list of Prescription Drug Products available in this program. If you choose not to participate, you will pay the cost share as described in the

Schedule of Benefits of this Outpatient Prescription Drug Plan. The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.

Outpatient Prescription Drug Plan Exclusions

Exclusions from coverage listed in this *SPD* also apply to this Outpatient Prescription Drug Plan. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
    - The acceptable standard medical reference compendia are the following:
        - The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.
        - The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.
        - *Thomson Micromedex Compendium DRUGDEX*.
        - *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
        - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
    - Medical literature may be accepted if all of the following apply:
        - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
        - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
        - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant

to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).

6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

8. Any product dispensed for the purpose of appetite suppression or weight loss.

9. A Pharmaceutical Product for which Benefits are provided under the medical Benefits portion of the Plan in this *SPD*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

10. Durable Medical Equipment for which Benefits are provided in this *SPD*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies, including certain insulin pumps and related supplies for the management and treatment of diabetes, and inhaler spacers specifically stated as covered.

11. General vitamins, except the following, which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

12. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as a unit dose or unit doses.

13. Prescription Drug Products used for cosmetic or convenience purposes.

14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.

15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility.

17. Certain Prescription Drug Products for tobacco cessation.

18. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

19.
The following over-the-counter drugs or products:

- Drugs or products available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Claims Administrator has designated the over-the-counter drugs or products as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.
- Over-the-counter continuous glucose monitors.

The following Prescription Drug Products with over-the-counter alternatives:

- Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.
- Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator PDL Management Committee.

21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury except for Eosinophilic Gastrointestinal Disorder Formula or for Medical Foods prescribed for the treatment of Inherited Metabolic Disorder in *Section 3: Defined Terms* of this *section* or for Medically Necessary treatment of an eating disorder.

23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another covered Prescription Drug Product or Pharmaceutical Product available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. Certain Prescription Drug Products that have not been prescribed by a Specialist.

27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product.

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

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

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

Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

29. Diagnostic kits and products including associated services.

30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

31. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

32. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

33. Prescription Drug Products prescribed by a provider who is on UnitedHealthcare's list of excluded providers due to fraud, waste, and/or abuse findings.

Outpatient Prescription Drug Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by the Claims Administrator.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Eosinophilic Gastrointestinal Disorder Formula - amino acid-based formula used in the treatment of a Covered Person who has been diagnosed as having an eosinophilic gastrointestinal disorder, subject to the following conditions:

- The Covered Person must be under the continuous supervision of a Physician who is licensed under Title 32, Chapter 13 or 17 of the Arizona Revised Statutes or a registered nurse practitioner who is licensed under Title 32, Chapter 15 of the Arizona Revised Statutes.
- The formula must be prescribed or ordered by a Physician or a registered nurse practitioner.
- There must be a risk of mental or physical impairment to the Covered Person without the use of the formula.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by the Claims Administrator.

Inherited Metabolic Disorder - a disease or disorder caused by an inherited abnormality of body chemistry, including a disease or disorder tested under the newborn screening program:

- Which involves amino acid, carbohydrate and fat metabolism.
- For which medically standard methods of diagnosis, treatment, and monitoring exist.
- Which requires specifically processed or treated Medical Foods that are generally available only under the supervision and direction of a Physician or a registered nurse practitioner with special training in the diagnosis and treatment of patients with genetic inborn errors of metabolism and that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

List of Vital Medications – a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at no cost to you. You may find the List of Vital Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Medical Foods - modified nutritional substances in any form that are all of the following:

- Used in the treatment of Inherited Metabolic Disorders to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- Formulated to be consumed or administered enterally under the supervision of a Physician or a registered nurse practitioner.
- Specifically processed or formulated to be deficient in one or more nutrients present in typical foodstuffs. This does not include a natural food or food product that is naturally low in protein.
- Intended for the medical and nutritional management of patients who have limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation.
- Essential to optimize growth, health, and metabolic homeostasis.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

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

- The date it is placed on a tier by the Claims Administrator PDL Management Committee.
- December 31st of the following calendar year.

Per Occurrence Deductible - the portion of the Allowed Amount, or the Recognized Amount when applicable (stated as a set dollar amount) that you must pay for certain Covered Health Care Services prior to, and in addition to, any Annual Deductible before the Plan begins paying Benefits for those Covered Health Care Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount, or the Recognized Amount when applicable.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. The Prescription Drug List is developed through an evidence-based evaluation when determining which Prescription Drug Products are covered or excluded under the Policy. Medications may be excluded from coverage when it works the same or similar as another prescription medication or an over-the-counter medication. This list is subject to the Claims Administrator's review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Outpatient Prescription Drug Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network pharmacy.
- Certain injectable medications administered in a Network Pharmacy.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and
    - glucose meters including continuous glucose monitors.

    Including the following diabetic supplies required by Arizona state law:

    - blood glucose monitors;
    - blood glucose monitors for the legally blind;
    - test strips for glucose monitors and visual reading and urine testing strips;
    - insulin preparations and glucagon;
    - insulin cartridges;

- drawing up devices and monitors for the visually impaired;
- injection aids;
- insulin cartridges for the legally blind;
- syringes and lancets, including automatic lancing devices;
- prescribed oral agents for controlling blood sugar; and
- any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products or Pharmaceutical Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by the Claims Administrator, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information, please visit www.uhcprovider.com under the following path: Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act $0 Cost-Share Preventive Medications Exemption Requests (Commercial Members).

Federal Notice

Language Assistance Services

ATTENTION: If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-866-633-2446. (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા
વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

УВАГА: Якщо ви розмовляєте **українською мовою (Ukrainian)**, у вас є можливість скористатися безкоштовними послугами перекладача. Зателефонуйте, будь ласка, за номером 1-866-633-2446.

AADACHT: Wann du **Deitsch Schwetze (Pennsylvanian Dutch)** kann, kannscht du frei Schprooch aushilfe griege. Ruf Nummer 1-866-633-2446.

FAAALIGA: Afai e te tautala Faa-**Samoa (Samoan)**, o loo avanoa tautua mo fesoasoani tau gagana mo oe, e le totogia. Faamolemole telefoni le 1-866-633-2446.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

The Claims Administrator[1] complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity). The Claims Administrator does not exclude people or treat them less favorably because of race, color, national origin, age disability or sex.

The Claims Administrator provides free aids and services to help you communicate with them. You can ask for interpreters and/or for communications in other languages or formats such as large print. The Claims Administrator also provides reasonable modifications for persons with disabilities.

If you need these services, please call 1-866-633-2446 or the toll-free member phone number on your member ID card, TTY/RTT 711.

If you believe that the Claims Administrator failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your ID card, TTY 711.

You can also file a complaint with the U.S. Department. of Health and Human Services, Office for Civil Rights.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of this Non-Discrimination Notice ("Notice"), "The Claims Administrator" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Summary Plan Description (SPD)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* to be grandfathered a plan must have been in effect on March 23, 2010 and had no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time(among other requirements).

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health care and substance-related and addictive disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and long-term disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential health benefits for plan years beginning on or after January 1, 2014 cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. As of September 23, 2010, if you have a grandfathered plan, the group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). For plan years beginning January 1, 2014 and beyond, Grandfathered plans are required to cover dependents up to age 26, regardless of their eligibility for other employer sponsored coverage.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If you do not have a grandfathered plan, network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, Coinsurance or Copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, Coinsurance or Copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - 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*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the plan is permitted, with 30 days advance written notice, only in the following two circumstances:

  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.

- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
    - Direct access to OB/GYN care without a referral or authorization requirement.
    - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
    - Prior authorization is not required before you receive services in the emergency department of a hospital.

      If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (Copayments/Coinsurance) will be the same as would be applied to care received from network providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered persons participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or *UnitedHealthcare* for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call the Claims Administrator at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The first denial letter or *Explanation of Benefits* that you receive from the Claims Administrator will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will take place as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call the Claims Administrator at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give the Claims Administrator additional information supporting your claim. Send the information to the address provided in the first denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the first denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, the Claims Fiduciary will review its decision. The Claims Fiduciary will also send you its written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, the Claims Fiduciary will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call the Claims Administrator at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Call the Claims Administrator at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also call the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

(http://www.dol.gov.ebsa/healthreform/ - click link for Consumer Assistance Programs).

For information on appeals and other PPACA regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health Care or Substance - Related and Addictive Disorder Services, the following applies:

Mental Health Care/Substance-Related and Addictive Disorder Services Parity

Effective for grandfathered and non-grandfathered large group Plans that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health care conditions and substance-related and addictive disorder conditions that are Covered Health Care Services under the Plan must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Care Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Coinsurance and Copayments for mental health care and substance-related and addictive disorder conditions must be no more restrictive than those Coinsurance and Copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health care and substance-related and Addictive disorder benefits. Based upon the results of that testing, it is possible that Coinsurance or Copayments that apply to mental health care conditions and substance-related and addictive disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

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

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, the Claims Administrator will send you written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

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

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

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

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

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

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

Concurrent Care Claims

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

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

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact call the Claims Administrator at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact the Claims Administrator and later wish to request a formal appeal in writing, you should again contact the Claims Administrator and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact the Claims Administrator, immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of the Claims Administrator's decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

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

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2023

The Claims Administrator[2] is required by law to protect the privacy of your health information. The Claims Administrator is also required to send you this notice, which explains how the Claims Administrator may use information about you and when the Claims Administrator can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. The Claims Administrator is required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information the Claims Administrator maintains that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The Claims Administrator will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

The Claims Administrator has the right to change its privacy practices and the terms of this notice. If the Claims Administrator makes a material change to its privacy practices, the Claims Administrator will provide to you, in the Claims Administrator's next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. The Claims Administrator will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if the Claims Administrator maintains a website for your particular health plan, the Claims Administrator will post the revised notice on your health plan website, such as www.myuhc.com. The Claims Administrator reserves the right to make any revised or changed notice effective for information the Claims Administrator already has and for information that the Claims Administrator receives in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer the Claims Administrator's business and to provide products, services and information of importance to Plan enrollees. The Claims Administrator maintains physical, electronic and procedural security safeguards in the handling and maintenance of Plan enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How the Claims Administrator Uses or Discloses Information

The Claims Administrator must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

The Claims Administrator has the right to use and disclose health information for your treatment, to pay for your health care and to operate the Claims Administrator's business. For example, the Claims Administrator may use or disclose your health information:

- **For Payment** of service fees due the Claims Administrator, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, the Claims Administrator may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** The Claims Administrator may use or disclose health information to aid in your treatment or the coordination of your care. For example, the Claims Administrator may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** The Claims Administrator may use or disclose health information as needed to operate and manage its business activities related to providing and managing your health care coverage. For example, the Claims Administrator might talk to your physician to suggest a disease management or wellness program that could help improve your health or the Claims Administrator may analyze data to determine how the Claims Administrator can improve its services. The Claims Administrator may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and the Claims Administrator may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, the Claims Administrator may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, the Claims Administrator may share other health information with the plan sponsor for plan administration purpose if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. The Claims Administrator may use or disclose your health information for underwriting purposes; however, the Claims Administrator will not use or disclose your genetic information for such purposes.
- **For Reminders.** The Claims Administrator may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** The Claims Administrator may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to the Claims Administrator.

The Claims Administrator may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** The Claims Administrator may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** The Claims Administrator may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, the Claims Administrator will use its best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when the Claims Administrator may disclose health information to family members and others involved in a deceased individual's care. The Claims Administrator may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless the Claims Administrator is aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** The Claims Administrator may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** The Claims Administrator may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. The Claims Administrator may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** The Claims Administrator may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **To Business Associates** that perform functions on the Claims Administrator's behalf or provide the Claims Administrator with services if the information is needed for such functions or services. The Claims Administrator's business associates are required, under contract with the Claims Administrator, and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown in the Claims Administrator's contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure**. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
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    10. Reproductive Health
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If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to the Claims Administrator, it is the Claims Administrator's intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, the Claims Administrator will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give the Claims Administrator authorization to release your health information, the Claims Administrator cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if the Claims Administrator has already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. The Claims Administrator may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while the Claims Administrator will try to honor your request and will permit requests consistent with the Claims Administrator's policies, the Claims Administrator is not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). The Claims Administrator will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, the Claims Administrator will accept your verbal request to receive confidential communications, however; the Claims Administrator may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and get a copy** of certain health information the Claims Administrator maintains about you such as claims and case or medical management records. If the Claims Administrator maintains your health information electronically, you will have the right to request that the Claims Administrator send a copy of your health information in an electronic format to you. You can also request that the Claims Administrator provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, the Claims Administrator may deny your request to inspect and copy your health information. If the Claims Administrator denies your request, you may have the right to have the denial reviewed. The Claims Administrator may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information the Claims Administrator maintains about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If the Claims Administrator denies your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by the Claims Administrator during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require the Claims Administrator to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll- free member phone number on your health plan ID card or you may call the Claims Administrator at 1-866-633-2446 or TTY 711.

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to the Claims Administrator at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Timing.** The Claims Administrator will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Claims Administrator at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. The Claims Administrator will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1,2023

The Claims Administrator[3] is committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with the Claims Administrator, the Claims Administrator may collect personal financial information about you from the following sources:

- Information the Claims Administrator receives from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with the Claims Administrator, the Claims Administrator's affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

The Claims Administrator does not disclose personal financial information about the Plan's enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of the Claims Administrator's general business practices, the Claims Administrator may, as permitted by law, disclose any of the personal financial information that the Claims Administrator collects about you without your authorization, to the following types of institutions:

- To the Claims Administrator's corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for the Claims Administrator's everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for the Claims Administrator, including sending promotional communications on the Claims Administrator's behalf.

Confidentiality and Security

The Claims Administrator maintains physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call the Claims Administrator at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, the "Claims Administrator" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Administrative Statement

Claims Fiduciary: The Claims Administrator is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan. The Claims Fiduciary shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Fiduciary shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: Your Plan is self-funded. The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Fiduciary. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Arizona State Retirement System (ASRS), the Plan Sponsor.

The Plan Sponsor has selected a provider Network established by UnitedHealthcare Insurance Company

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343
952-936-1300

Person designated as Agent for Service of Legal Process: Arizona State Retirement System (ASRS)

Arizona State Retirement System Health Plan

WRAP PLAN DOCUMENT

January 1, 2026

This document, together with the relevant Summary Plan Description and/or Evidence of Coverage document for the various Component Benefit Programs is your Plan Document. If you need a copy of a Summary Plan Document and/or Evidence of Coverage document, you should contact the ASRS.

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1. Introduction

The Arizona State Retirement System (ASRS), as Plan Sponsor, establishes and maintains the Arizona State Retirement System Health Plan for the exclusive benefit of its Members and their Dependents. This Wrap Plan Document, along with the relevant Summary Plan Description and/or Evidence of Coverage documents ("Governing Documents") for the various Component Benefit Programs, set forth the terms of the Plan as of January 1, 2026 and replaces all other plan documents and applicable amendments to those documents previously provided to Plan Participants and beneficiaries.

You are being provided this Wrap Plan Document to give you an overview of the Plan and to address certain information that may not be addressed in the relevant Governing Documents. This document is a "wrap" plan document that is not intended to give you any substantive rights to benefits that are not provided in relevant Governing Documents. You must read the this Wrap Plan Document together with the relevant Governing Documents to understand your benefits.

The Plan provides benefits through the following Component Benefit Programs:

- Medical Plans (including Prescription Drug coverage)
- Dental Plans

Each of these Component Benefit Programs is summarized in the relevant Governing Document. When the Plan refers to an insurance contract, it also refers to any attachments to such contract, as well as documents incorporated by reference into such contract (such as the application and the certificate of insurance booklet). This Wrap Plan Document, together with any relevant Governing Document constitute the Plan Document. A copy of each Governing Document is provided when you enroll. Please contact ASRS if you need a copy.

This Wrap Plan Document will help you understand and use the benefits provided by the Arizona State Retirement System Health Plan. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the Component Benefit Programs, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan.

All provisions of this document contain important information.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. The Quick Reference Chart to sources of help or information about the Plan follows this section.

Quick Reference Chart

When you need information, please check this booklet first. If you need further help, call the people listed in the following summary:

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION

For Information on:	You Should Contact:
Enrollment/Eligibility	Arizona State Retirement System 602-240-2000 Phoenix Area 800-621-3778 Out-of-Area AzASRS.gov Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan (CORP) & Elected Officials' Retirement Plans (EORP) Benefits Office: 602-255-5575
Plan Administrator • Eligibility Claims/Appeals • Premium Benefit • Premium Payments • COBRA Administration	Arizona State Retirement System 602-240-2000 Phoenix Area 800-621-3778 Out-of-Area AzASRS.gov Mailing Address: P.O. Box 33910 Phoenix, AZ 85067-3910
Medical Plan (pre-Medicare) • Benefits/Summary Plan Description • Participating Provider Directory • Preauthorization/Utilization Management • Prescription Drug Benefits • Medical/Prescription Drug Claims/Appeals	UnitedHealthcare 800-509-6729 whyuhc.com/asrs
Medical Plan (Medicare Advantage Plans) • Benefits/Summary Plan Description • Participating Provider Directory • Preauthorization/Utilization Management • Prescription Drug Benefits • Medical/Prescription Drug Claims/Appeals	UnitedHealthcare 844-876-6161 uhcretiree.com/asrs
PPO Dental Plan • Benefits/Evidence of Coverage • Participating Provider Directory • Dental Premium Payments • Dental Claims/Appeals	Delta Dental of Arizona 833-335-8201, TTY: 711 deltadentalaz.com/asrs

For Information on:	You Should Contact:
HMO Dental Plan • Benefits/Evidence of Coverage • Participating Provider Directory • Dental Premium Payments • Dental Claims/Appeals	Cigna 800-244-6224 Cigna.com/asrs
HIPAA Privacy Officer	Ryan Guerra Arizona State Retirement System P.O. Box 33910 Phoenix, AZ 85067-3910

2. Eligibility and Participation Requirements

Eligibility

You are eligible with respect to the Plan if:

- you are a Member who retired from the ASRS, Public Safety Personnel Retirement System (PSPRS), Elected Officials' Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP), or the Optional Retirement Plans (ORP); or

- are a Member who is receiving long-term disability benefits pursuant to Arizona Revised Statutes section 38-651.03 or article 2.1 of Arizona Revised Statutes, Title 38, Chapter 5; or

- are a designated beneficiary of a deceased Member who is receiving a survivor benefit pursuant to Arizona Revised Statutes section 38-762, subsection C, or section 38-763, subsection B as monthly income (hereinafter referred to as a Surviving Dependent); and

do not otherwise elect to obtain coverage under a group health and accident insurance plan or program, and are eligible to participate in and receive benefits under one or more of the Component Benefit Programs in accordance with the terms and conditions of the Plan (including the terms of the applicable Component Benefit Program).

Dual Enrollment

The ASRS provides the opportunity for its Members to enroll in the plan, but there are eligibility restrictions for individuals enrolled in other health plans (known as "Dual Enrollment"). ASRS retired Members, Members on ASRS Long Term Disability, Surviving Dependents of ASRS Members, and their Dependents may not be enrolled in the ASRS health plan at the same time they are enrolled in another group health and accident plan or program.

Similarly, retired Members of the PSPRS, the EORP Plan, the CORP, the ORP, or other retirement plans that might be offered by the community college districts, and their Dependents may not be enrolled in an ASRS health plan while also enrolled in a health plan offered by the Arizona Department of Administration (ADOA).

Some Members may have more than one source of eligibility, however, individuals are limited to one enrollment at a time. For example, you may be eligible to enroll in a plan due to your participation in the ASRS and another eligible retirement plan, but you may only be enrolled in a plan in one capacity at a time—either as a Member or Dependent.

Additionally, if you and your spouse are both eligible to enroll in a plan, you cannot enroll each other as Dependents, nor have your children enrolled twice. One spouse may elect coverage for the entire family, or each spouse may elect their own coverage. Dependent children can be on one spouse's policy or divided between spouses, but cannot be enrolled as a Dependent of both spouses.

If the ASRS determines a Participant has prohibited dual coverage, enrollment in the ASRS Plan will be terminated, no refunds for any premiums you paid will be issued, and overpayments made by the ASRS plan will be recovered.

Eligible Dependents

Other individuals, such as a spouse or dependent children of a Member who is retired or a Member on ASRS Long Term Disability, may be eligible to participate in and receive benefits under one or more of the Component Benefit Programs. Dependents eligible for coverage include:

- Your legal spouse;
- Your natural child, legally adopted or placed for adoption child, or stepchild under the age of 26;
- Foster children under the age of 26;
- A child for whom legal guardianship has been awarded to you or your legal spouse, under the age of 26. You will be required to submit documentation as proof of legal guardianship;
- A child for whom insurance is required through a Qualified Medical Child Support Order, court order, or administrative order;
- A child of any age who is, or becomes, disabled and is dependent upon you. All disabled children age 26 or older must be approved by the Plan as a disabled dependent.[1]

Note: Participants eligible for coverage as a Surviving Dependent are not themselves eligible to enroll dependents except as required under COBRA.

Enrollment and Qualifying Live Events

A qualifying life event allows you the opportunity to enroll and/or make changes to existing coverage for yourself or your dependents outside of the annual Open Enrollment period.
You must make these changes no later than 31 calendar days from the date the qualifying event took place, unless a different deadline is indicated for a specific qualifying life event.
The following are the Qualifying Life Events recognized by the ASRS for enrollment and/or changes to your existing coverage outside of the annual Open Enrollment period. ASRS has the sole discretion to determine whether a Qualifying Life Event has occurred and whether your situation allows you to enroll or make changes to existing coverage.

[1] If your dependent child turning age 26 is disabled and you want your disabled child to continue coverage, you must notify the Plan Administrator and provide a written application within 60 days of your child's 26th birthday. Medical history from a physician regarding your child's disabled status may be required as part of this application. You are encouraged to obtain such information in advance of any application to prevent any lapse in coverage.

Retirement

New retirees are able to enroll and add dependent coverage in any plan they are eligible for at the time of their retirement. Supporting documentation will not be required, unless you wish to cover a dependent child over the age of 26.

Your insurance application must be submitted within 31 days of your retirement date. Coverage will be effective on the first day of the month following your retirement date. Health insurance premium deductions (retroactive to your coverage effective date) will not be deducted from your monthly pension payment until your retirement benefit has been finalized.

Change in marital status

You may change plans, and/or add dependent coverage for new dependents resulting from a new marriage, including the spouse if you are a current participant under the Plan. Retirees who are not current participants must wait until the next open enrollment period to add spouse and new dependents as a result of a new marriage.

If the change in marital status results in the loss of other coverage (for example due to divorce, legal separation, annulment, or the death of a spouse), you and your dependents may enroll in a plan or change plans. You may (and must in the case of a spouse) also remove a dependent due to a change in marital status such as divorce, legal separation, annulment, or death of a spouse.

You will be asked to provide documentation that supports the occurrence of this qualifying life event.

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective on the first day of the month after you submit your enrollment application.

Change in dependent status

You may enroll in a plan, change plans and/or add dependent coverage for new dependents resulting from a change in dependent status such as a birth or adoption, even if you declined to enroll in a plan during the previous Open Enrollment Period. In such cases, you may also add a dependent not previously covered.

You may also remove dependent coverage in the event of a change in dependent status. You will be asked to provide documentation that supports the occurrence of this qualifying life event.

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective as of the date of the change in dependent status (i.e. on the date of birth, adoption, or placement for adoption), provided you submit your enrollment application for coverage within the 31 days.

Change Relating to Medicaid or Children's Health Insurance Program (CHIP)

If you or your dependents become eligible for a Medicaid or CHIP subsidy or lose coverage under Medicaid or CHIP, you may enroll in a plan, change plans, and/or add or remove dependent coverage. Supporting documentation will be required.

Your enrollment application can be submitted within 60 days of the date you or your dependent is determined to be eligible for the subsidy or the date coverage is terminated. Coverage will be effective on the first day of the month after you submit your enrollment application.

Change in primary residence

You may change plans, and/or add or remove dependents if you have a change in your place of residence affecting your current coverage through ASRS. Your address on file with the ASRS must correspond to the coverage area in which you are enrolling (Arizona or nationwide).

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective on the first day of the month after you submit your enrollment application for coverage.

Change in Medicare eligibility

You may enroll in a Medicare medical plan when you become Medicare eligible. If you and/or your dependent are already enrolled in non-Medicare medical coverage through the ASRS, you and/or your dependent must switch to a Medicare plan upon becoming Medicare eligible. Failure to enroll in a Medicare plan will result in the termination of coverage for you and/or your dependent. If this occurs, you may not be able to re-enroll in an ASRS medical plan unless you have a Qualifying Life Event or until the next Open Enrollment Period.

Please note: Medicare eligibility is NOT a Qualifying Life Event for dental plans - only for medical plans.

Your enrollment application can be submitted 90 days prior to your Medicare eligibility date. Coverage will be effective on the first day of the month you become Medicare eligible.

If you are already enrolled in a Medicare Advantage plan you may be able to make changes to your plan outside of the annual Open Enrollment Period in other special circumstances. Please refer to Medicare.gov for more information regarding special circumstances.

You can also speak with a Medicare specialist by calling (800) 432-4040 if you reside in Arizona, or you can check the Medicare.gov website for contact information if you reside outside of Arizona.

Loss of other coverage and other events (spouse, employer, COBRA)

You may enroll in a plan, change plans and/or add dependent coverage when:

- you or your dependent has lost group or individual health insurance coverage due to a loss of eligibility for the coverage (including termination of employment or reduction in hours, but not including a failure to pay premiums, voluntary termination of coverage and termination of coverage for cause, such as for fraud),

- the group medical plan option in which you or your dependent are enrolled terminates or ends,
- you or your dependent's coverage under a non-calendar year plan ends at the end of that plan's year and you or your dependent do not renew coverage under that plan, resulting in a loss of coverage.
- You or your dependent exhaust COBRA continuation coverage under a different plan.
- The employer sponsoring the medical group plan in which you or your dependent are enrolled ceases making contributions towards the cost of coverage—even if you do not actually lose coverage.

Please note: You will be asked to provide documentation that supports the qualifying life event. Voluntarily terminating your non-ASRS group or individual medical insurance plan is not a qualifying life event.

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective on the first day of the month after you submit your enrollment application.

Long Term Disability

If you are approved for the ASRS Long Term Disability Program, you may enroll yourself and your dependents in any plan for which you are eligible. Supporting documentation will not be required, unless you wish to cover a dependent child over the age of 26.

Your enrollment application must be submitted within 31 days of the date on your ASRS Health Insurance Eligibility notification letter or your LTD benefit effective date, whichever date is later. Coverage will be effective on the first day of the month after you submit your enrollment application.

To request special enrollment or obtain more information, contact the Plan Administrator.

Note: Participants eligible for coverage as a Surviving Dependent are not themselves eligible to enroll Dependents except as required under COBRA.

Termination of Coverage

When a Member's participation in the Plan terminates, benefits under the Plan for the Member and the Member's Dependents covered under the Plan will cease, unless the Member has died and Dependents are eligible to continue coverage as Surviving Dependents. Termination of participation in a Component Benefit Program occurs in accordance with the terms and conditions established for that Component Benefit Program.

All benefits under the Component Benefit Program will cease upon termination of the Plan.

Other circumstances can result in the termination of benefits. The relevant Governing Documents for the Component Benefit Programs provide additional information.

Keep the Plan Informed

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. The contact information for the Plan Administrator can be found in the Quick Reference Chart at the front of this document.

3. Leaves of Absence

If your continued eligibility is related to your active employment status, you may be entitled to continued eligibility for coverage under the Plan when on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States. In those limited circumstances, the following provisions regarding leave will apply.

Family and Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), you may be able to take up to 12 weeks of unpaid leave during any 12-month period:

- to care for a newly born or adopted child;
- to care for a spouse, parent or child who has a serious health problem;
- if you have a serious health problem that prevents you from performing your job; or
- a qualifying exigencies arising out of the fact that the active Participant's spouse, son, daughter, or parent is on active duty or has been notified of an impending call or order to active duty, in support of a contingency operation.

In addition, the FMLA may enable you to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member if that individual is your spouse, son/daughter, parent or next of kin, is undergoing treatment or therapy for an illness or injury that occurred in the line of duty, and is an outpatient or on the armed services' temporary disability retired list.

To be eligible for an FMLA leave, you must have worked for your employer for 1,250 hours during the 12 consecutive month period before your leave is scheduled to begin. Any paid or unpaid leave time taken during the year is counted against your annual FMLA allowance. You must provide 30 days of notice when the need for an FMLA leave is foreseeable. When the need for a leave comes up unexpectedly, you must provide as much advance notice as possible. Medical certification regarding your or a family member's serious health condition will be required.

If you qualify for FMLA leave, the Plan will maintain the coverage you were eligible for at the time of your leave until the end of your leave.

Leave for Military Service

If you voluntarily or involuntarily leave your employment position to undertake military service, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994 requires an employer to grant you unpaid military leave for up to five years and to continue to subsidize your health care coverage for up to 31 days from the first day of your military leave. If your military service exceeds 31 days, you should receive military health care coverage from the U.S. Government at no cost. However, you may also elect to continue your coverage under this Plan for you and your Dependents covered under the Plan for a maximum period of 24 months

from the first day of your military leave. You must notify the Benefits Office at the beginning of your military leave and fill out an election form in order to receive this continuation of coverage.

Once the Plan Administrator receives notice that the Member has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Member (and any Dependents covered under the Plan on the day the leave started). If the Member does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Contact the Plan Administrator to obtain a copy of the USERRA election forms. Completed USERRA election forms should be submitted to the Plan as soon as possible, but in no event more than 90 days after the Plan offers the right to elect USERRA coverage.

The Participant (and any Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the Participant continues to pay the appropriate contributions for that coverage during the period of that leave. If the Participant elects USERRA temporary continuation coverage, the Participant (and any Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to twenty-four (24) months measured from the date the Member stopped working. USERRA coverage will be 102% of the cost of coverage. Coverage under USERRA will terminate due to non-payment of premiums, subject to a 30-day grace period.

In addition, your Dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE. Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

If your continued eligibility is related to your active employment, then when you are discharged (not less than honorably) from military service, your full eligibility will be reinstated on the day you return to employment with the ASRS, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

You must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. If you have any questions about how a leave of absence affects your coverage, please contact the Plan Administrator. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Keep the Plan Informed

In order to protect your family's rights, keep the Plan Administrator informed of any changes for participants such as addresses and your marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. The contact information for the Plan Administrator can be found in the Quick Reference Chart at the front of this document.

4. COBRA Continuation of Coverage

In General

If you are enrolled in a non-Medicare health plan or a dental plan, your Dependents can continue health care and/or dental coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the coverage provided under this Plan and may be available at the enrollees' own expense provided coverage is lost due to a "COBRA Qualifying Event."

Note for Retirees: When you retired, you (the Member) were offered a choice between electing a temporary continuation of your active group health coverage ("COBRA Continuation Coverage") or electing retiree health coverage. As you elected retiree health coverage, you have no further COBRA continuation rights. However, your Dependent(s) may experience a COBRA Qualifying Event as described in this section.

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of COBRA Qualifying Event, a Qualified Beneficiary can include any Dependent who is covered by the Plan when a COBRA Qualifying Event occurs. Qualified Beneficiaries have the same rights as Members or Dependents including special and open enrollment rights. For example, a child who becomes a Dependent by birth, adoption, or placement for adoption to someone enrolled under COBRA is also a Qualified Beneficiary. As with any Qualifying Life Events, you must provide written notice to the Plan Administrator within 31 days of such an event.

If COBRA coverage applies, your Dependents have the option to continue the same medical and/or dental coverage they had prior to the COBRA Qualifying Event.

Alternatives to Coverage

There may be other health coverage alternatives to COBRA available that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace, there may be available tax credits that lower your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you or your Dependents may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

COBRA Qualifying Events

To be eligible to elect COBRA coverage, your Dependent must **lose** coverage due to any one of the following COBRA Qualifying Events:

COBRA Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
You become legally separated or divorced from your spouse	Eligible spouse and stepchildren (only step-children will lose coverage upon legal separation or divorce)	36 months
Your dependent child is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit)	Eligible dependent child	36 months

Availability of COBRA Coverage

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a COBRA Qualifying Event has occurred. You or your family should notify the Plan Administrator promptly if any such COBRA Qualifying Event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notice.

Notice of COBRA Qualifying Events

You must notify the Plan Administrator in writing no later than 60 days after the COBRA Qualifying Event occurs. The notice of occurrence of any of these events must be provided to the Plan Administrator in writing. Notice may be provided by the Participant or Qualified Beneficiary with respect to the COBRA Qualifying Event, or any representative acting on behalf of the Participant or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same COBRA Qualifying Event. You must provide the Plan Administrator written notice of the following COBRA Qualifying Events:

1. When a Participant divorces or legally separates from his or her spouse, written notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the COBRA Qualifying Event. A copy of the court document acknowledging the legal separation or divorce must be included with the notice.

2. When a dependent child ceases to be covered under the Plan (including turning age 26), written notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the COBRA Qualifying Event.

Failing to provide written notice to the Plan Administrator within the timeframe described above may prevent your Dependents from obtaining or extending the COBRA coverage. After receiving written notice of a COBRA Qualifying Event, the Plan will provide an election notice for a Qualified Beneficiary within 14 days.

Further, when a dependent child who is covered turns 26 years old, they are no longer eligible to be covered under the ASRS plans. Dependent children who are age 26 will be automatically terminated from coverage. There will not be any notification of this required

change. To ensure that you are aware of upcoming changes, please keep track of your Dependents' eligibility based on age.

Notice of Unavailability of COBRA Coverage

In the event the Plan Administrator is notified of a potential COBRA Qualifying Event but the Plan Administrator determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why the COBRA coverage is not available. This notice of the unavailability of the COBRA coverage will be sent within 14 days after the Plan Administrator receives written notice of a potential COBRA Qualifying Event.

How is COBRA Coverage Provided?

When the Plan Administrator is notified that a COBRA Qualifying Event has occurred, the Plan Administrator will then provide you and/or your Dependents with notice of the date on which coverage will end, and the information and election form that individuals will need in order to elect COBRA coverage. Under the law, you and/or your Dependents will then have only 60 days from the later of the date they ordinarily would have lost coverage because of the COBRA Qualifying Events, or the date your Dependents received the notice, to apply for COBRA coverage.

Each Qualified Beneficiary has an independent/separate right to elect COBRA coverage. COBRA coverage may be elected for some members of the family and not others. In addition, one or more Dependents may elect COBRA even if others eligible to elect COBRA do not. However, in order to elect COBRA coverage, the family members must have been covered by the Plan on the date of the COBRA Qualifying Event or became a Dependent by birth, adoption, or placement for adoption during the period of COBRA coverage.

Payment for COBRA Coverage

When your Dependents become entitled to this coverage, the Plan Administrator will provide notice regarding the COBRA premium amounts. Those who continue coverage under COBRA are responsible for the entire cost of COBRA coverage and pay for the coverage on a monthly basis. The cost of COBRA is up to 102% of the Plan's cost.

If your Dependents elect COBRA coverage, no payment needs to be sent along with the Election Form. However, the first COBRA payment must be sent to the Plan Administrator not later than 45 days after the date of the COBRA election (which is the date the Election Notice is post-marked, if mailed). If the first payment for COBRA is not paid in full within 45 days after the date of the COBRA election, all continuation coverage rights under the Plan will be lost.

Grace Period for Payments

Although payments are due on the first day of the month, there will be given a grace period of 30 days after the first day of the coverage period to make each payment. COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before

the end of the grace period for that payment. If the Plan Administrator has not received a COBRA payment by the due date (the first of the month), COBRA coverage will be cancelled on the first day of the month. However, if the COBRA premium is paid within the 30-day grace period coverage will be reinstated back to the first day of that COBRA coverage period. Payment is considered made when it is postmarked.

Early Termination of COBRA Coverage

COBRA coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The first date of the time period for which COBRA premiums are not paid within the required timeframe after electing COBRA.
- The date, after the date of the COBRA election, in which your Dependent(s) first become covered by another group health Plan.
- The date, after the date of the COBRA election, on which your Dependent(s) first become entitled to Medicare (usually age 65); or
- The date the Plan terminates its group health plan and no longer provides group health insurance coverage to its Members.

Notice of Early Termination of COBRA Coverage

The Plan Administrator will notify the Qualified Beneficiary(ies) if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the COBRA Qualifying Event that entitled the Qualified Beneficiary(ies) to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary(ies) may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (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.

COBRA Questions or to Give Notice of Changes in Your Circumstances

For more information about rights under 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan Informed

In order to protect your family's rights, keep the Plan Administrator informed of any changes for participants such as addresses and your marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. The contact information for the Plan Administrator can be found in the Quick Reference Chart at the front of this document.

5. Plan Benefits

Available Benefits

The Plan makes available to you and your eligible family members medical and dental insurance. The Governing Document for each Component Benefit Program, describing the benefits provided under the program, was provided along with this Wrap Plan Document when you enrolled. You should contact ASRS if you need a copy of any Governing Document.

Payment of Premiums

Your ASRS health insurance premiums will be automatically deducted each month from your ASRS pension payment, if your pension payment amount is greater than the net cost of your insurance premiums. The premium benefit may be delayed for one to three months while your pension is finalized. However, the eligible amount will be reimbursed or adjusted, as applicable, and will be retroactive to the beginning of the coverage.

The medical and/or the dental benefit administrator/carrier will mail a bill directly to you and it will be your responsibility to pay premiums directly to the administrator/carrier if you are:

- On Long Term Disability
- Choosing your employer's options (State of Arizona is an exception. The payment will be withheld from your ASRS pension payment)
- Receiving a pension payment that does not cover the net cost of your insurance premiums.

Premium Benefit

As part of your benefits, the ASRS provides a health insurance premium benefit to supplement the cost of retiree health insurance. The premium benefit is effective on the first day of the month following your initial enrollment or special enrollment. Members who are either retirees or on Long Term Disability, and have five or more years of credited service who have health insurance through the ASRS or non-subsidized coverage through their former ASRS employer are eligible for a monthly premium benefit, which is paid to the health insurer or your former employer. A premium benefit also applies to eligible retirees participating in the ASRS health insurance plans from EORP, CORP and PSPRS.

If you are a new ASRS retiree, you may elect to receive a reduced premium benefit that, upon your death, may be continued to your beneficiary. This Optional Premium Benefit is only available to retirees who select a Term Certain or Joint & Survivor Annuity option. It is not available to retirees who select the Straight Life Annuity. You have a one-time opportunity to elect this benefit when you retire. You may rescind election at a later date and the unreduced premium benefit will be reinstated and applied for life.

The amount of the Optional Premium Benefit reduction is based on your age and the age of your beneficiary. You can find out what your reduction would be by visiting the Calculating Your Optional Premium Benefit page of our website at www.bit.ly/Premium-Calc.

Administrative Requirements and Timelines

As described in the Governing Documents for each Component Benefit Program, there may be reasons that a claim for benefits under a particular Component Benefit Program is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. For details regarding administrative requirements that may impact benefit availability, please see governing documents for the relevant Component Benefit Program.

Rebates, Refunds and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable fiduciary obligations.

Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the ASRS (or designee), or the applicable insurance company may recover that incorrect payment, whether or not it resulted from the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to a Component Benefit Program provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured Component Benefit Program, subrogation or reimbursement rights may be set forth in the Governing Documents for the Component Benefit Programs.

Participant Responsibilities

Each Participant shall be responsible for providing the Plan Administrator and the ASRS and, if required by an insurance company with respect to a fully insured benefit, the insurance company with his or her current address and, if required, with the address of any individual covered through the Participant. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first-class United States mail. The insurance companies, the Plan Administrator, and the ASRS shall have no obligation or duty to locate a Participant.

Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is performs an act, practice or omission that constitutes fraud or makes an intentional mispresentation of material fact (such as, but not limited to, falsifying any document in support of a claim for benefits or coverage under the Plan, or failing to have corrected information which such person knows or should have known to be incorrect, or failing to bring such misinformation to the attention of the Plan Administrator or the insurance company), the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively rescinding coverage. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Participant related to the person's fraud or misrepresentation of material fact. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

HIPAA Nondiscrimination

This Plan will not discriminate against similarly situated individuals in eligibility, continued eligibility for benefits, individual premiums or contribution rates due to health factors such as health status, medical condition, claims experience, receipt of health care, medical history, genetic information or evidence of insurability. Benefits provided are uniformly available and any benefit restrictions are uniformly applied to all similarly situated individuals.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans, like this Plan, 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 may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans 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, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

This Plan covers a Hospital stay of at least 72 hours following a modified radical mastectomy and a Hospital stay of at least 48 hours following a simple mastectomy. A shorter length of stay may be covered if the patient, in consultation with her physician, determines that it is Medically Necessary and Appropriate. The patient's Provider does not need to obtain Prior Authorization for prescribing 72 or 48 hours, as appropriate, of Inpatient care.

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- 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.
- Prostheses; and
- The treatment of physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending provider and the patient.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other services covered under this Plan.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, an employer may

not request or require any genetic information from you or your family members. The Plan will not, with respect to you or your dependents:

- Discriminate on the basis of genetic information;
- Collect genetic information prior to in connection with enrollment or for underwriting purposes; or
- Require you or your dependent to undergo a genetic test.

Mental Healthy Parity

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers that offer mental health and substance use disorder benefits to offer those benefits without imposing less favorable benefit limitations on those benefits than medical/surgical benefits. If the Plan provides mental health/substance use disorder benefits in any classification of benefits, the Plan will provide mental health/substance use disorder benefits in every classification in which medical/surgical benefits are provided. The Plan will ensure that financial requirements (such as co-pays and deductibles) and quantitative treatment limitations (such as annual visits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements of limitations applied to substantially all medical/surgical benefits. The Plan will not impose non-quantitative limitations with respect to mental health/substance abuse disorder benefits in any classification unless under the terms of the Plan, the processes, strategies, evidentiary standards and other factors used in applying the non-quantitative limitation are comparable and no more stringently applied that with respect to medical/surgical benefits in the classification. As a government plan, the Plan is not subject to ERISA. However, participants shall have the right to request plan documents and information from the Plan pertaining to whether the plan is providing benefits in accordance with mental health parity.

No Surprises Act

The No Surprises Act protects employees from surprise medical bills (balance billing, out-of-network cost-sharing) when they receive emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. Beginning January 1, 2022, if you receive plan-covered services that are also covered by the No Surprises Act, your cost-sharing will be the same as if you had received those services from an in-network provider. The Plan will also provide continuity of coverage for continuing care patients where a termination of a provider's contractual arrangement changes the network status of the provider.

Qualified Medical Child Support Orders (QMSCOs)

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO), including a National Medical Support Order (NMSO). These are support orders of a court or state administrative agency that usually results

from a divorce or legal separation. The Benefits Office has the following QMCSO Procedures described below.

A Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. (A QMCSO also includes a National Medical Support Notice.) A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to provide for a child's health plan coverage;
- Indicates the name and last known address of the parent required to provide the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any child of the Member, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Member, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the Member is covered by the Plan, and advise them of the procedures to be followed to provide coverage for the child(ren).

If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions. The Benefits Office will accept enrollment of the alternate recipient specified by the QMCSO from either the Member or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the date the enrollment request and required documentation are received by the Plan Administrator. If you have not enrolled in the Plan, you will be required to enroll when you enroll your child. Coverage will be subject to all of the Plan's otherwise applicable terms, provisions, limitations and rules.

No coverage will be provided for any alternate recipient under a QMCSO unless the all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied.

Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the

Plan for other children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See the COBRA Continuation of Coverage section for more information.

6. How the Plan is Administered

Plan Operations and Administration

Because benefits under the Plan are provided both through insurance contracts and on a self-funded basis, the Plan is administered by the ASRS (for the insured and self-funded Component Benefit Programs) and the insurance companies (for the insured Component Benefit Programs).

The ASRS is the Plan Administrator. As the Plan Administrator, the ASRS is responsible for satisfying certain legal requirements with respect to the Plan (for example, distributing certain notices).

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

To the fullest extent permitted by law, the Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including Component Benefit Programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including Component Benefit Programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits.

Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

The ASRS will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Companies

Certain benefits under the Plan are fully insured. These benefits are provided under group insurance contracts entered into between the ASRS and the applicable insurance companies.

Claims for benefits under these component programs are submitted to the insurance companies. The insurance companies, not the ASRS, are responsible for determining and paying claims.

The insurance companies are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to insured component benefits under the Plan. (See the Claims Procedures section below for more information about claims.)

As the named fiduciary for benefit determinations for the insured component benefits, the insurance companies, to the fullest extent permitted by law, have the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

7. Circumstances That May Affect Benefits

Denial, Loss, and Recovery of Benefits

Your benefits (and the benefits of your covered family members) will cease when your participation in the Plan terminates, including upon termination of the Plan.

Other circumstances can result in the termination, reduction, or denial of benefits. The Plan also has the right to recover overpaid benefits and to seek subrogation or reimbursement in certain circumstances and with respect to certain Component Benefit Programs. The applicable Governing Documents provide additional information about the termination, denial, or loss of benefits, and about the Plan's recovery, subrogation, and reimbursement rights.

Plan Termination

Benefits will cease upon termination of the Plan.

Coordination of Benefits

As noted above (see Section 2), there are eligibility restrictions for individuals enrolled in other health plans (known and "Dual Enrollment"). Dual Enrollment eligibility is determined by the Arizona State Retirement System and applicable State of Arizona law. In the event this and another plan provide coverage, Coordination of benefits (COB) provisions establish the order in which plans pay their claims, and permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses. COB under the Plan is determined in accordance with the COB rules of the applicable Component Benefit Program. Before relying on the coordination of benefits and dual coverage descriptions, participants should first make a determination whether dual coverage eligibility exists. Contact the Arizona State Retirement System for assistance.

8. Amendment or Termination of the Plan

The ASRS, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the ASRS or any of its delegates. For this purpose, amending the Plan includes making changes to a Component Benefit Program. Terminating a Component Benefit Program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

The ASRS may sign insurance contracts for this Plan, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

9. Claims and Appeals Information

Eligibility determinations to participate in a Component Benefit Program are made by the ASRS. Appeals of plan eligibility determinations are handled by the ASRS following its rules. For claims and appeals regarding benefits provided through a Component Benefit Program, the ASRS has delegated to each contracted plan provider or insurer the authority to interpret and apply the terms of each Component Benefit Program. The contracted plan provider or insurer shall be the Claims Administrator for their respective Component Benefit Programs. For a complete explanation of your rights regarding specific benefits claims and appeals under a Component Benefit Program, please refer to the relevant Governing Documents. These materials, outlining the claims and appeals procedures for each of these plans are provided when your enroll, without charge, as separate documents.

Eligibility Determinations and Appeals

The ASRS makes initial eligibility determinations for enrollment in the various Component Benefit Programs. If you disagree with an initial eligibility determination, you have the right to appeal the ASRS determination. You may initiate this appeal process by writing a letter of appeal to Plan Administrator whose contact information is listed on the Quick Reference Chart in this document. Details regarding the process for appealing eligibility determinations are available at www.azasrs.gov/content/member-appeals.

Claims and Appeals for Benefits Under Component Benefit Programs

For purposes of determining the amount of and entitlement to benefits of the Component Benefit Programs, the respective contracted plan provider or insurer is the Claims Administrator and fiduciary under the Plan, and has the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Component Benefit. To obtain benefits of a Component Benefit Program, you must follow the claims procedures. (See relevant Governing Document for more information.)

The Claims Administrator will decide your claim in accordance with its reasonable claims procedures, as required by applicable law. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Claims Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Claims Administrator for a review of the denied claim. The Claims Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain Component Benefit Programs you may also have the right to obtain external review (that is, review outside of the Plan). See the relevant Summary Plan Description or Evidence of Coverage document for more information about the claims process for insured benefits.

Claims Deadline

Unless specifically provided otherwise in a Component Benefit Program or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Programs) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Participant or covered family member, or his or her designee, to make sure this requirement is met.

Limitations on Filing Suit

Unless specifically provided otherwise in a Component Benefit Program or pursuant to applicable law, a lawsuit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

Language Assistance

If you are not proficient in English and have questions about a claim denial, contact the Plan Administrator to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 800-621-3778.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 800-621-3778.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 800-621-3778.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-621-3778.

10. General Information

Plan Amendments or Termination of Plan

The ASRS reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

Amendments to the Plan may be made in writing by the ASRS and become effective upon the date as may be specified in the document amending the Plan.

The Plan or any coverage under it may be terminated by the ASRS, and new coverages may be added by the ASRS. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Allocation and Disposition of Assets Upon Termination

In order for the ASRS to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Plan Administrator has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Plan may be terminated by the Plan Administrator, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Plan Administrator, in its full discretion, will determine the disposition of any assets remaining after all expenses of the Plan have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Plan Administrator (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Non-Assignment

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Participant, a Dependent or creditor of the Participant without the express written permission of the Plan Sponsor; however, a Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under any law, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder.

Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

Statement of the ASRS Rights

The ASRS makes no representation that employment with it represents lifetime security or a guarantee of continued employment. Further, your eligibility or rights to benefits under this Plan should not be interpreted as a guarantee of employment.

The ASRS, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of participants, as defined by law.

Any written or oral statement other than a written statement signed by any agent of the ASRS that is contrary to the provisions of this subchapter **is invalid**, and no prospective, active or former employee or retiree should rely on any such statement.

The terms of this Plan Document supersede the terms of any contrary information about the Plan, or the Plan's eligibility, benefits, limits or exclusions that is provided orally or in writing to a participant by an employer or anyone other than the Plan Administrator.

No Liability for Practice of Medicine

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. This right extends to the right and opportunity to request an autopsy or other forensic exam in case of death where it is not forbidden by law. The cost of such an examination will be paid by the Plan. The Plan's right to require a physical examination does not extend to the individual's eligibility to enroll or continued eligibility to participate in the Plan.

Type of Administration

The ASRS self-funds medical and prescription drug benefits under the Plan for some Component Benefit Programs. Claims for these benefits are administered by independent claims administrators as listed on the Quick Reference Chart section. The funding for the benefits is derived from the Arizona State Retirement System Health Trust.

Independent insurance companies (whose name and address are listed on the Quick Reference Chart in the front of this document) administer the fully insured benefits of this Plan (including the Dental PPO and Dental HMO benefits) and provide payment of claims associated with these benefits.

Claims Review Fiduciary (Claims Administrator)

Benefit Programs	**Funding**	**Claims Administrator** (Contact information listed on the Quick Reference Chart in the front of this document)
Medical (pre-Medicare)	Self-funded	UnitedHealthcare
Prescription Drug (pre-Medicare)	Self-funded	UnitedHealthcare
Medical (Medicare Advantage)	Insured	UnitedHealthcare
Prescription Drug (Medicare Advantage)	Insured	UnitedHealthcare
Dental PPO	Insured	Delta Dental
Dental HMO	Insured	Cigna

No Guarantee of Tax Consequences

Notwithstanding any provision in the Plan (including the Component Benefit Programs) to the contrary, neither the Plan nor the ASRS makes any commitment or guarantee that any amounts paid to or on behalf of a Participant under the Plan will be excludable from gross income for federal or state income tax purposes.

Governing Law

The Plan shall be construed and enforced according to the laws of Arizona, except to the extent required by federal law.

Severability

In the event that any provision of this Plan (including the Component Benefit Programs) is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been part of the Plan.

NOTICE REGARDING WELLNESS PROGRAM

The Real Appeal program is a voluntary wellness program available to all enrollees in the ASRS medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or otherwise provide medical information.

However, Participants who choose to participate in the wellness program will receive an incentive of a success kit including a weight and food scale, exercise DVDs, personal blender, and personalized coaching for losing weight and keeping it off. Although you are not required to complete the HRA or otherwise provide medical information, only Participants who do so will receive the incentive.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as personalized coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the ASRS may use aggregate

information it collects to design a program based on identified health risks in the workplace, Real Appeal will never disclose any of your personal information either publicly or to the ASRS, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the ASRS at 800-621-3778.

11. HIPAA Privacy and Security

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that group health plans maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

The term PHI includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by the ASRS or an employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, and Family and Medical Leave (FMLA).

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Plan Administrator. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor will not use or further disclose PHI except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

The Plan's Use and Disclosure of PHI

The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

- Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

- Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing Member contributions for coverage;

- Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

- Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- Health Care Operations includes, but is not limited to:

  - Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

  - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

  - Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

  - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

  - Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

When an Authorization Form is Needed

Generally, the Plan will require that you sign a valid authorization form (available from the Plan Administrator) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

The Plan shall not use or disclose your substance use disorder treatment records unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the

individual or holder of the record, as provided under law. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

When the Plan Will Disclosure PHI to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

- Not use or disclose the information for employment-related actions and decisions;
- Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of PHI disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Notify you if a breach of your unsecured protected health information (PHI) occurs.

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan Administrator,

2. Staff designated by the Plan Administrator

3. Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization network, utilization management company.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer, whose address and phone number are listed on the Quick Reference Chart in the front of this document.

Hybrid Entity

For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options with outpatient prescription drug benefits, and COBRA administration.

HIPAA Security

In compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

- Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

12. Definitions

"Claims Administrator" means the person or persons delegated responsibility and fiduciary authority by the ASRS to administer claims and appeals under the different Component Benefit Programs.

"Component Benefit Program" is a vehicle through which the Plan provides substantive rights to benefits. Each Component Benefit Program is summarized in a Summary Plan Description and/or Evidence of Coverage document, insurance contract, plan document, or another governing document.

"Dependent" means an individual, such as a Member's spouse, children, or other family members, who may be eligible to participate in and receive benefits under one or more of the Component Benefit Programs due to their relationship to a Member.

"**Member**" means a person who participates in the Arizona State Retirement System (ASRS), Public Safety Personnel Retirement System (PSPRS), Elected Officials' Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP), or the Optional Retirement Plans of the Arizona University System (ORP).

"**Participant**" means a Member who is retired or on Long Term Disability, or their Dependent who are covered under the Plan.

"Plan" means the Arizona State Retirement System Health Plan.

"**Plan Administrator**" means the Arizona State Retirement System (ASRS).

"**Plan Sponsor**" means the Arizona State Retirement System (ASRS).

"**Plan Year**" means the 12-month period beginning each January 1 and ending each December 31.